

CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5304

53rd Legislature
1993 Regular Session

Passed by the Senate April 23, 1993
YEAS 28 NAYS 21

President of the Senate

Passed by the House April 21, 1993
YEAS 56 NAYS 42

**Speaker of the
House of Representatives**

Approved

CERTIFICATE

I, Marty Brown, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE SENATE BILL 5304** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

Governor of the State of Washington

**Secretary of State
State of Washington**

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5304

AS RECOMMENDED BY THE CONFERENCE COMMITTEE

Passed Legislature - 1993 Regular Session

State of Washington 53rd Legislature 1993 Regular Session

By Senate Committee on Ways & Means (originally sponsored by Senators Talmadge, Gaspard, Moore, Deccio, Wojahn, Moyer, Snyder, Winsley, Fraser, Haugen, McAuliffe, Drew, Sheldon, Skratek and Pelz)

Read first time 03/08/93.

1 AN ACT Relating to health care; amending RCW 70.47.010, 70.47.020,
2 70.47.030, 70.47.040, 70.47.060, 70.47.080, 41.05.011, 41.05.021,
3 41.05.050, 41.05.055, 41.05.065, 41.05.120, 41.05.140, 47.64.270,
4 74.09.055, 19.68.010, 70.05.010, 70.05.030, 70.05.040, 70.05.050,
5 70.05.070, 70.05.080, 70.05.120, 70.05.130, 70.05.150, 70.08.010,
6 70.12.030, 70.12.050, 70.46.020, 70.46.060, 70.46.080, 70.46.085,
7 70.46.090, 70.46.120, 82.44.110, 82.44.155, 43.20.030, 70.170.100,
8 70.170.110, 28B.125.010, 28B.115.080, 70.185.030, 43.70.460, 43.70.470,
9 48.30.300, 48.44.260, 48.46.380, 48.44.095, 48.14.080, 82.04.260,
10 82.04.4289, 82.24.020, 82.24.080, 82.26.020, 82.08.150, 66.24.290,
11 82.02.030, 43.70.320, 70.41.200, 70.41.230, 5.60.070, 4.22.070,
12 43.84.092, 42.17.2401, and 43.20.050; reenacting and amending RCW
13 28A.400.200, 28A.400.350, 48.21.200, and 48.46.080; adding a new
14 section to chapter 70.47 RCW; adding new sections to chapter 41.05 RCW;
15 adding a new section to Title 43 RCW; adding new sections to chapter
16 70.05 RCW; adding new sections to chapter 70.170 RCW; adding a new
17 section to chapter 70.41 RCW; adding new sections to chapter 18.68 RCW;
18 adding a new section to chapter 18.51 RCW; adding new sections to
19 chapter 70.185 RCW; adding a new section to chapter 48.18 RCW; adding
20 a new section to chapter 48.20 RCW; adding a new section to chapter
21 48.21 RCW; adding new sections to chapter 48.44 RCW; adding new

1 sections to chapter 48.46 RCW; adding a new section to chapter 48.01
2 RCW; adding a new section to chapter 48.14 RCW; adding a new section to
3 chapter 82.04 RCW; adding new sections to chapter 18.130 RCW; adding
4 new sections to chapter 43.70 RCW; adding a new section to chapter
5 48.22 RCW; adding a new section to chapter 48.05 RCW; adding new
6 sections to chapter 7.70 RCW; adding a new chapter to Title 43 RCW;
7 adding new chapters to Title 48 RCW; creating new sections; recodifying
8 RCW 70.08.010; repealing RCW 70.05.005, 70.05.020, 70.05.132,
9 70.05.145, 70.12.005, 70.46.030, 70.46.040, 70.46.050, 48.46.160,
10 48.46.905, 48.44.410, and 82.04.4288; prescribing penalties; providing
11 effective dates; and declaring an emergency.

12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

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1

PART I. FINDINGS, GOALS, AND INTENT

2 NEW SECTION. **Sec. 101.** FINDINGS. The legislature finds that our
3 health and financial security are jeopardized by our ever increasing
4 demand for health care and by current health insurance and health
5 system practices. Current health system practices encourage public
6 demand for unneeded, ineffective, and sometimes dangerous health
7 treatments. These practices often result in unaffordable cost
8 increases that far exceed ordinary inflation for essential care.
9 Current total health care expenditure rates should be sufficient to
10 provide access to essential health care interventions to all within a
11 reformed, efficient system.

12 The legislature finds that too many of our state's residents are
13 without health insurance, that each year many individuals and families
14 are forced into poverty because of serious illness, and that many must
15 leave gainful employment to be eligible for publicly funded medical
16 services. Additionally, thousands of citizens are at risk of losing
17 adequate health insurance, have had insurance canceled recently, or
18 cannot afford to renew existing coverage.

19 The legislature finds that businesses find it difficult to pay for
20 health insurance and remain competitive in a global economy, and that
21 individuals, the poor, and small businesses bear an inequitable health
22 insurance burden.

23 The legislature finds that persons of color have significantly
24 higher rates of mortality and poor health outcomes, and substantially
25 lower numbers and percentages of persons covered by health insurance
26 than the general population. It is intended that chapter . . . , Laws
27 of 1993 (this act) make provisions to address the special health care
28 needs of these racial and ethnic populations in order to improve their
29 health status.

30 The legislature finds that uncontrolled demand and expenditures for
31 health care are eroding the ability of families, businesses,
32 communities, and governments to invest in other enterprises that
33 promote health, maintain independence, and ensure continued economic
34 welfare. Housing, nutrition, education, and the environment are all
35 diminished as we invest ever increasing shares of wealth in health care
36 treatments.

1 The legislature finds that while immediate steps must be taken, a
2 long-term plan of reform is also needed.

3 NEW SECTION. **Sec. 102.** LEGISLATIVE INTENT AND GOALS. (1) The
4 legislature intends that state government policy stabilize health
5 services costs, assure access to essential services for all residents,
6 actively address the health care needs of persons of color, improve the
7 public's health, and reduce unwarranted health services costs to
8 preserve the viability of nonhealth care businesses.

9 (2) The legislature intends that:

10 (a) Total health services costs be stabilized and kept within rates
11 of increase similar to the rates of personal income growth within a
12 publicly regulated, private marketplace that preserves personal choice;

13 (b) State residents be enrolled in the certified health plan of
14 their choice that meets state standards regarding affordability,
15 accessibility, cost-effectiveness, and clinical efficaciousness;

16 (c) State residents be able to choose health services from the full
17 range of health care providers, as defined in section 402(12) of this
18 act, in a manner consistent with good health services management,
19 quality assurance, and cost effectiveness;

20 (d) Individuals and businesses have the option to purchase any
21 health services they may choose in addition to those included in the
22 uniform benefits package or supplemental benefits;

23 (e) All state residents, businesses, employees, and government
24 participate in payment for health services, with total costs to
25 individuals on a sliding scale based on income to encourage efficient
26 and appropriate utilization of services;

27 (f) These goals be accomplished within a reformed system using
28 private service providers and facilities in a way that allows consumers
29 to choose among competing plans operating within budget limits and
30 other regulations that promote the public good; and

31 (g) A policy of coordinating the delivery, purchase, and provision
32 of health services among the federal, state, local, and tribal
33 governments be encouraged and accomplished by chapter . . . , Laws of
34 1993 (this act).

35 (3) Accordingly, the legislature intends that chapter . . . , Laws
36 of 1993 (this act) provide both early implementation measures and a
37 process for overall reform of the health services system.

1 **PART II. EARLY IMPLEMENTATION MEASURES**

2 **A. BASIC HEALTH PLAN EXPANSION**

3 NEW SECTION. **Sec. 201.** A new section is added to chapter 70.47
4 RCW to read as follows:

5 TRANSFER OF POWER AND DUTIES TO WASHINGTON STATE HEALTH CARE
6 AUTHORITY. The powers, duties, and functions of the Washington basic
7 health plan are hereby transferred to the Washington state health care
8 authority. All references to the administrator of the Washington basic
9 health plan in the Revised Code of Washington shall be construed to
10 mean the administrator of the Washington state health care authority.

11 NEW SECTION. **Sec. 202.** TRANSFER OF RECORDS, EQUIPMENT, FUNDS.
12 All reports, documents, surveys, books, records, files, papers, or
13 written material in the possession of the Washington basic health plan
14 shall be delivered to the custody of the Washington state health care
15 authority. All cabinets, furniture, office equipment, motor vehicles,
16 and other tangible property used by the Washington basic health plan
17 shall be made available to the Washington state health care authority.
18 All funds, credits, or other assets held by the Washington basic health
19 plan shall be assigned to the Washington state health care authority.

20 Any appropriations made to the Washington basic health plan shall,
21 on the effective date of this section, be transferred and credited to
22 the Washington state health care authority. At no time may those funds
23 in the basic health plan trust account, any funds appropriated for the
24 subsidy of any enrollees, or any premium payments or other sums made or
25 received on behalf of any enrollees in the basic health plan be
26 commingled with any appropriated funds designated or intended for the
27 purposes of providing health care coverage to any state or other public
28 employees.

29 Whenever any question arises as to the transfer of any personnel,
30 funds, books, documents, records, papers, files, equipment, or other
31 tangible property used or held in the exercise of the powers and the
32 performance of the duties and functions transferred, the director of
33 financial management shall make a determination as to the proper
34 allocation and certify the same to the state agencies concerned.

35 NEW SECTION. **Sec. 203.** TRANSFER OF EMPLOYEES. All employees of
36 the Washington basic health plan are transferred to the jurisdiction of

1 the Washington state health care authority. All employees classified
2 under chapter 41.06 RCW, the state civil service law, are assigned to
3 the Washington state health care authority to perform their usual
4 duties upon the same terms as formerly, without any loss of rights,
5 subject to any action that may be appropriate thereafter in accordance
6 with the laws and rules governing state civil service.

7 NEW SECTION. **Sec. 204.** RULES AND BUSINESS. All rules and all
8 pending business before the Washington basic health plan shall be
9 continued and acted upon by the Washington state health care authority.
10 All existing contracts and obligations shall remain in full force and
11 shall be performed by the Washington state health care authority.

12 NEW SECTION. **Sec. 205.** VALIDITY OF PRIOR ACTS. The transfer of
13 the powers, duties, functions, and personnel of the Washington basic
14 health plan shall not affect the validity of any act performed prior to
15 the effective date of this section.

16 NEW SECTION. **Sec. 206.** APPORTIONMENT OF BUDGETED FUNDS. If
17 apportionments of budgeted funds are required because of the transfers
18 directed by sections 201 through 205 of this act, the director of
19 financial management shall certify the apportionments to the agencies
20 affected, the state auditor, and the state treasurer. Each of these
21 shall make the appropriate transfer and adjustments in funds and
22 appropriation accounts and equipment records in accordance with the
23 certification.

24 NEW SECTION. **Sec. 207.** COLLECTIVE BARGAINING. Nothing contained
25 in sections 201 through 206 of this act may be construed to alter any
26 existing collective bargaining unit or the provisions of any existing
27 collective bargaining agreement until the agreement has expired or
28 until the bargaining unit has been modified by action of the personnel
29 board as provided by law.

30 **Sec. 208.** RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each
31 amended to read as follows:

32 BASIC HEALTH PLAN--FINDINGS. (1) The legislature finds that:

1 (a) A significant percentage of the population of this state does
2 not have reasonably available insurance or other coverage of the costs
3 of necessary basic health care services;

4 (b) This lack of basic health care coverage is detrimental to the
5 health of the individuals lacking coverage and to the public welfare,
6 and results in substantial expenditures for emergency and remedial
7 health care, often at the expense of health care providers, health care
8 facilities, and all purchasers of health care, including the state; and

9 (c) The use of managed health care systems has significant
10 potential to reduce the growth of health care costs incurred by the
11 people of this state generally, and by low-income pregnant women (~~who~~
12 ~~are an especially vulnerable population, along with their children~~),
13 and at-risk children and adolescents who need greater access to managed
14 health care.

15 (2) The purpose of this chapter is to provide or make more readily
16 available necessary basic health care services in an appropriate
17 setting to working persons and others who lack coverage, at a cost to
18 these persons that does not create barriers to the utilization of
19 necessary health care services. To that end, this chapter establishes
20 a program to be made available to those residents (~~under sixty-five~~
21 ~~years of age~~) not (~~otherwise~~) eligible for medicare (~~with gross~~
22 ~~family income at or below two hundred percent of the federal poverty~~
23 ~~guidelines~~) who share in a portion of the cost or who pay the full
24 cost of receiving basic health care services from a managed health care
25 system.

26 (3) It is not the intent of this chapter to provide health care
27 services for those persons who are presently covered through private
28 employer-based health plans, nor to replace employer-based health
29 plans. However, the legislature recognizes that cost-effective and
30 affordable health plans may not always be available to small business
31 employers. Further, it is the intent of the legislature to expand,
32 wherever possible, the availability of private health care coverage and
33 to discourage the decline of employer-based coverage.

34 (4) (~~The program authorized under this chapter is strictly limited~~
35 ~~in respect to the total number of individuals who may be allowed to~~
36 ~~participate and the specific areas within the state where it may be~~
37 ~~established. All such restrictions or limitations shall remain in full~~
38 ~~force and effect until quantifiable evidence based upon the actual~~
39 ~~operation of the program, including detailed cost benefit analysis, has~~

1 ~~been presented to the legislature and the legislature, by specific act~~
2 ~~at that time, may then modify such limitations.))~~

3 (a) It is the purpose of this chapter to acknowledge the initial
4 success of this program that has (i) assisted thousands of families in
5 their search for affordable health care; (ii) demonstrated that low-
6 income, uninsured families are willing to pay for their own health care
7 coverage to the extent of their ability to pay; and (iii) proved that
8 local health care providers are willing to enter into a public-private
9 partnership as a managed care system.

10 (b) As a consequence, the legislature intends to extend an option
11 to enroll to certain citizens above two hundred percent of the federal
12 poverty guidelines within the state who reside in communities where the
13 plan is operational and who collectively or individually wish to
14 exercise the opportunity to purchase health care coverage through the
15 basic health plan if the purchase is done at no cost to the state. It
16 is also the intent of the legislature to allow employers and other
17 financial sponsors to financially assist such individuals to purchase
18 health care through the program so long as such purchase does not
19 result in a lower standard of coverage for employees.

20 (c) The legislature intends that, to the extent of available funds,
21 the program be available throughout Washington state to subsidized and
22 nonsubsidized enrollees. It is also the intent of the legislature to
23 enroll subsidized enrollees first, to the maximum extent feasible.

24 (d) The legislature directs that the basic health plan
25 administrator identify enrollees who are likely to be eligible for
26 medical assistance and assist these individuals in applying for and
27 receiving medical assistance. The administrator and the department of
28 social and health services shall implement a seamless system to
29 coordinate eligibility determinations and benefit coverage for
30 enrollees of the basic health plan and medical assistance recipients.

31 **Sec. 209.** RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each
32 amended to read as follows:

33 BASIC HEALTH PLAN--DEFINITIONS. As used in this chapter:

34 (1) "Washington basic health plan" or "plan" means the system of
35 enrollment and payment on a prepaid capitated basis for basic health
36 care services, administered by the plan administrator through
37 participating managed health care systems, created by this chapter.

1 (2) "Administrator" means the Washington basic health plan
2 administrator, who also holds the position of administrator of the
3 Washington state health care authority.

4 (3) "Managed health care system" means any health care
5 organization, including health care providers, insurers, health care
6 service contractors, health maintenance organizations, or any
7 combination thereof, that provides directly or by contract basic health
8 care services, as defined by the administrator and rendered by duly
9 licensed providers, on a prepaid capitated basis to a defined patient
10 population enrolled in the plan and in the managed health care system.
11 On and after July 1, 1995, "managed health care system" means a
12 certified health plan, as defined in section 402 of this act.

13 (4) "Subsidized enrollee" means an individual, or an individual
14 plus the individual's spouse (~~((and/or))~~) or dependent children, (~~((all~~
15 ~~under the age of sixty-five and))~~) not (~~((otherwise))~~) eligible for
16 medicare, who resides in an area of the state served by a managed
17 health care system participating in the plan, whose gross family income
18 at the time of enrollment does not exceed twice the federal poverty
19 level as adjusted for family size and determined annually by the
20 federal department of health and human services, who the administrator
21 determines at the time of application does not have health insurance
22 more comprehensive than that offered by the plan, and who chooses to
23 obtain basic health care coverage from a particular managed health care
24 system in return for periodic payments to the plan.

25 (5) "Nonsubsidized enrollee" means an individual, or an individual
26 plus the individual's spouse or dependent children, not eligible for
27 medicare, who resides in an area of the state served by a managed
28 health care system participating in the plan, who the administrator
29 determines at the time of application does not have health insurance
30 more comprehensive than that offered by the plan, who chooses to obtain
31 basic health care coverage from a particular managed health care
32 system, and who pays or on whose behalf is paid the full costs for
33 participation in the plan, without any subsidy from the plan.

34 (6) "Subsidy" means the difference between the amount of periodic
35 payment the administrator makes(~~((, from funds appropriated from the~~
36 ~~basic health plan trust account,))~~) to a managed health care system on
37 behalf of (~~((an))~~) a subsidized enrollee plus the administrative cost to
38 the plan of providing the plan to that subsidized enrollee, and the

1 amount determined to be the subsidized enrollee's responsibility under
2 RCW 70.47.060(2).

3 ~~((+6))~~ (7) "Premium" means a periodic payment, based upon gross
4 family income ~~((and determined under RCW 70.47.060(2),))~~ which an
5 ~~((enrollee))~~ individual, their employer or another financial sponsor
6 makes to the plan as consideration for enrollment in the plan as a
7 subsidized enrollee or a nonsubsidized enrollee.

8 ~~((+7))~~ (8) "Rate" means the per capita amount, negotiated by the
9 administrator with and paid to a participating managed health care
10 system, that is based upon the enrollment of subsidized and
11 nonsubsidized enrollees in the plan and in that system.

12 **Sec. 210.** RCW 70.47.030 and 1992 c 232 s 907 are each amended to
13 read as follows:

14 ACCOUNTS. (1) The basic health plan trust account is hereby
15 established in the state treasury. ~~((All))~~ Any nongeneral fund-state
16 funds collected for this program shall be deposited in the basic health
17 plan trust account and may be expended without further appropriation.
18 Moneys in the account shall be used exclusively for the purposes of
19 this chapter, including payments to participating managed health care
20 systems on behalf of enrollees in the plan and payment of costs of
21 administering the plan. ~~((After July 1, 1993, the administrator shall~~
22 ~~not expend or encumber for an ensuing fiscal period amounts exceeding~~
23 ~~ninety five percent of the amount anticipated to be spent for purchased~~
24 ~~services during the fiscal year.))~~

25 (2) The basic health plan subscription account is created in the
26 custody of the state treasurer. All receipts from amounts due from or
27 on behalf of nonsubsidized enrollees shall be deposited into the
28 account. Funds in the account shall be used exclusively for the
29 purposes of this chapter, including payments to participating managed
30 health care systems on behalf of nonsubsidized enrollees in the plan
31 and payment of costs of administering the plan. The account is subject
32 to allotment procedures under chapter 43.88 RCW, but no appropriation
33 is required for expenditures.

34 (3) The administrator shall take every precaution to see that none
35 of the funds in the separate accounts created in this section or that
36 any premiums paid either by subsidized or nonsubsidized enrollees are
37 commingled in any way, except that the administrator may combine funds

1 designated for administration of the plan into a single administrative
2 account.

3 **Sec. 211.** RCW 70.47.040 and 1987 1st ex.s. c 5 s 6 are each
4 amended to read as follows:

5 BASIC HEALTH PLAN--PROGRAM WITHIN STATE HEALTH CARE AUTHORITY. (1)
6 The Washington basic health plan is created as (~~(an independent agency~~
7 ~~of the state)) a program within the Washington state health care
8 authority. The administrative head and appointing authority of the
9 plan shall be the administrator (~~(who shall be appointed by the~~
10 ~~governor, with the consent of the senate, and shall serve at the~~
11 ~~pleasure of the governor. The salary for this office shall be set by~~
12 ~~the governor pursuant to RCW 43.03.040)) of the Washington state health
13 care authority. The administrator shall appoint a medical director.
14 The (~~(administrator,)~~) medical director(~~(,)~~) and up to five other
15 employees of the plan shall be exempt from the civil service law,
16 chapter 41.06 RCW.~~~~

17 (2) The administrator shall employ such other staff as are
18 necessary to fulfill the responsibilities and duties of the
19 administrator, such staff to be subject to the civil service law,
20 chapter 41.06 RCW. In addition, the administrator may contract with
21 third parties for services necessary to carry out its activities where
22 this will promote economy, avoid duplication of effort, and make best
23 use of available expertise. Any such contractor or consultant shall be
24 prohibited from releasing, publishing, or otherwise using any
25 information made available to it under its contractual responsibility
26 without specific permission of the plan. The administrator may call
27 upon other agencies of the state to provide available information as
28 necessary to assist the administrator in meeting its responsibilities
29 under this chapter, which information shall be supplied as promptly as
30 circumstances permit.

31 (3) The administrator may appoint such technical or advisory
32 committees as he or she deems necessary. The administrator shall
33 appoint a standing technical advisory committee that is representative
34 of health care professionals, health care providers, and those directly
35 involved in the purchase, provision, or delivery of health care
36 services, as well as consumers and those knowledgeable of the ethical
37 issues involved with health care public policy. Individuals appointed
38 to any technical or other advisory committee shall serve without

1 compensation for their services as members, but may be reimbursed for
2 their travel expenses pursuant to RCW 43.03.050 and 43.03.060.

3 (4) The administrator may apply for, receive, and accept grants,
4 gifts, and other payments, including property and service, from any
5 governmental or other public or private entity or person, and may make
6 arrangements as to the use of these receipts, including the undertaking
7 of special studies and other projects relating to health care costs and
8 access to health care.

9 (5) (~~In the design, organization, and administration of the plan~~
10 ~~under this chapter, the administrator shall consider the report of the~~
11 ~~Washington health care project commission established under chapter~~
12 ~~303, Laws of 1986. Nothing in this chapter requires the administrator~~
13 ~~to follow any specific recommendation contained in that report except~~
14 ~~as it may also be included in this chapter or other law)) Whenever
15 feasible, the administrator shall reduce the administrative cost of
16 operating the program by adopting joint policies or procedures
17 applicable to both the basic health plan and employee health plans.~~

18 **Sec. 212.** RCW 70.47.060 and 1992 c 232 s 908 are each amended to
19 read as follows:

20 ADMINISTRATOR'S POWERS AND DUTIES. The administrator has the
21 following powers and duties:

22 (1) To design and from time to time revise a schedule of covered
23 basic health care services, including physician services, inpatient and
24 outpatient hospital services, prescription drugs and medications, and
25 other services that may be necessary for basic health care, which
26 subsidized and nonsubsidized enrollees in any participating managed
27 health care system under the Washington basic health plan shall be
28 entitled to receive in return for premium payments to the plan. The
29 schedule of services shall emphasize proven preventive and primary
30 health care and shall include all services necessary for prenatal,
31 postnatal, and well-child care. However, (~~for the period ending June~~
32 ~~30, 1993,~~) with respect to coverage for groups of subsidized enrollees
33 who are eligible to receive prenatal and postnatal services through the
34 medical assistance program under chapter 74.09 RCW, the administrator
35 shall not contract for (~~prenatal or postnatal~~) such services (~~that~~
36 ~~are provided under the medical assistance program under chapter 74.09~~
37 ~~RCW~~) except to the extent that such services are necessary over not
38 more than a one-month period in order to maintain continuity of care

1 after diagnosis of pregnancy by the managed care provider(~~(, or except~~
2 ~~to provide any such services associated with pregnancies diagnosed by~~
3 ~~the managed care provider before July 1, 1992)~~). The schedule of
4 services shall also include a separate schedule of basic health care
5 services for children, eighteen years of age and younger, for those
6 subsidized or nonsubsidized enrollees who choose to secure basic
7 coverage through the plan only for their dependent children. In
8 designing and revising the schedule of services, the administrator
9 shall consider the guidelines for assessing health services under the
10 mandated benefits act of 1984, RCW 48.42.080, and such other factors as
11 the administrator deems appropriate. On and after July 1, 1995, the
12 uniform benefits package adopted and from time to time revised by the
13 Washington health services commission pursuant to section 449 of this
14 act shall be implemented by the administrator as the schedule of
15 covered basic health care services. However, with respect to coverage
16 for subsidized enrollees who are eligible to receive prenatal and
17 postnatal services through the medical assistance program under chapter
18 74.09 RCW, the administrator shall not contract for such services
19 except to the extent that the services are necessary over not more than
20 a one-month period in order to maintain continuity of care after
21 diagnosis of pregnancy by the managed care provider.

22 (2)(a) To design and implement a structure of periodic premiums due
23 the administrator from subsidized enrollees that is based upon gross
24 family income, giving appropriate consideration to family size (~~as~~
25 ~~well as~~) and the ages of all family members. The enrollment of
26 children shall not require the enrollment of their parent or parents
27 who are eligible for the plan. The structure of periodic premiums
28 shall be applied to subsidized enrollees entering the plan as
29 individuals pursuant to subsection (9) of this section and to the share
30 of the cost of the plan due from subsidized enrollees entering the plan
31 as employees pursuant to subsection (10) of this section.

32 (b) To determine the periodic premiums due the administrator from
33 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
34 shall be in an amount equal to the cost charged by the managed health
35 care system provider to the state for the plan plus the administrative
36 cost of providing the plan to those enrollees and the appropriate
37 premium tax as provided by law.

38 (c) An employer or other financial sponsor may, with the prior
39 approval of the administrator, pay the premium, rate, or any other

1 amount on behalf of a subsidized or nonsubsidized enrollee, by
2 arrangement with the enrollee and through a mechanism acceptable to the
3 administrator, but in no case shall the payment made on behalf of the
4 enrollee exceed the total premiums due from the enrollee.

5 (3) To design and implement a structure of ((nominal)) copayments
6 due a managed health care system from subsidized and nonsubsidized
7 enrollees. The structure shall discourage inappropriate enrollee
8 utilization of health care services, but shall not be so costly to
9 enrollees as to constitute a barrier to appropriate utilization of
10 necessary health care services. On and after July 1, 1995, the
11 administrator shall endeavor to make the copayments structure of the
12 plan consistent with enrollee point of service cost-sharing levels
13 adopted by the Washington health services commission, giving
14 consideration to funding available to the plan.

15 (4) ~~((To design and implement, in concert with a sufficient number~~
16 ~~of potential providers in a discrete area, an enrollee financial~~
17 ~~participation structure, separate from that otherwise established under~~
18 ~~this chapter, that has the following characteristics:~~

19 ~~(a) Nominal premiums that are based upon ability to pay, but not~~
20 ~~set at a level that would discourage enrollment;~~

21 ~~(b) A modified fee for services payment schedule for providers;~~

22 ~~(c) Coinsurance rates that are established based on specific~~
23 ~~service and procedure costs and the enrollee's ability to pay for the~~
24 ~~care. However, coinsurance rates for families with incomes below one~~
25 ~~hundred twenty percent of the federal poverty level shall be nominal.~~
26 ~~No coinsurance shall be required for specific proven prevention~~
27 ~~programs, such as prenatal care. The coinsurance rate levels shall not~~
28 ~~have a measurable negative effect upon the enrollee's health status;~~
29 ~~and~~

30 ~~(d) A case management system that fosters a provider-enrollee~~
31 ~~relationship whereby, in an effort to control cost, maintain or improve~~
32 ~~the health status of the enrollee, and maximize patient involvement in~~
33 ~~her or his health care decision-making process, every effort is made by~~
34 ~~the provider to inform the enrollee of the cost of the specific~~
35 ~~services and procedures and related health benefits.~~

36 The potential financial liability of the plan to any such providers
37 shall not exceed in the aggregate an amount greater than that which
38 might otherwise have been incurred by the plan on the basis of the
39 number of enrollees multiplied by the average of the prepaid capitated

1 rates negotiated with participating managed health care systems under
2 RCW 70.47.100 and reduced by any sums charged enrollees on the basis of
3 the coinsurance rates that are established under this subsection.

4 ~~(5))~~) To limit enrollment of persons who qualify for subsidies so
5 as to prevent an overexpenditure of appropriations for such purposes.
6 Whenever the administrator finds that there is danger of such an
7 overexpenditure, the administrator shall close enrollment until the
8 administrator finds the danger no longer exists.

9 (5) To limit the payment of subsidies to subsidized enrollees, as
10 defined in RCW 70.47.020.

11 (6) To adopt a schedule for the orderly development of the delivery
12 of services and availability of the plan to residents of the state,
13 subject to the limitations contained in RCW 70.47.080 or any act
14 appropriating funds for the plan.

15 ~~((In the selection of any area of the state for the initial~~
16 ~~operation of the plan, the administrator shall take into account the~~
17 ~~levels and rates of unemployment in different areas of the state, the~~
18 ~~need to provide basic health care coverage to a population reasonably~~
19 ~~representative of the portion of the state's population that lacks such~~
20 ~~coverage, and the need for geographic, demographic, and economic~~
21 ~~diversity.~~

22 ~~Before July 1, 1988, the administrator shall endeavor to secure~~
23 ~~participation contracts with managed health care systems in discrete~~
24 ~~geographic areas within at least five congressional districts.))~~

25 (7) To solicit and accept applications from managed health care
26 systems, as defined in this chapter, for inclusion as eligible basic
27 health care providers under the plan. The administrator shall endeavor
28 to assure that covered basic health care services are available to any
29 enrollee of the plan from among a selection of two or more
30 participating managed health care systems. In adopting any rules or
31 procedures applicable to managed health care systems and in its
32 dealings with such systems, the administrator shall consider and make
33 suitable allowance for the need for health care services and the
34 differences in local availability of health care resources, along with
35 other resources, within and among the several areas of the state.
36 Contracts with participating managed health care systems shall ensure
37 that basic health plan enrollees who become eligible for medical
38 assistance may, at their option, continue to receive services from
39 their existing providers within the managed health care system if such

1 providers have entered into provider agreements with the department of
2 social and health services.

3 (8) To receive periodic premiums from or on behalf of subsidized
4 and nonsubsidized enrollees, deposit them in the basic health plan
5 operating account, keep records of enrollee status, and authorize
6 periodic payments to managed health care systems on the basis of the
7 number of enrollees participating in the respective managed health care
8 systems.

9 (9) To accept applications from individuals residing in areas
10 served by the plan, on behalf of themselves and their spouses and
11 dependent children, for enrollment in the Washington basic health plan
12 as subsidized or nonsubsidized enrollees, to establish appropriate
13 minimum-enrollment periods for enrollees as may be necessary, and to
14 determine, upon application and at least ((annually)) semiannually
15 thereafter, or at the request of any enrollee, eligibility due to
16 current gross family income for sliding scale premiums. ((An enrollee
17 who remains current in payment of the sliding scale premium, as
18 determined under subsection (2) of this section, and whose gross family
19 income has risen above twice the federal poverty level, may continue
20 enrollment unless and until the enrollee's gross family income has
21 remained above twice the poverty level for six consecutive months, by
22 making payment at the unsubsidized rate required for the managed health
23 care system in which he or she may be enrolled.)) No subsidy may be
24 paid with respect to any enrollee whose current gross family income
25 exceeds twice the federal poverty level or, subject to RCW 70.47.110,
26 who is a recipient of medical assistance or medical care services under
27 chapter 74.09 RCW. If, as a result of an eligibility review, the
28 administrator determines that a subsidized enrollee's income exceeds
29 twice the federal poverty level and that the enrollee knowingly failed
30 to inform the plan of such increase in income, the administrator may
31 bill the enrollee for the subsidy paid on the enrollee's behalf during
32 the period of time that the enrollee's income exceeded twice the
33 federal poverty level. If a number of enrollees drop their enrollment
34 for no apparent good cause, the administrator may establish appropriate
35 rules or requirements that are applicable to such individuals before
36 they will be allowed to re-enroll in the plan.

37 (10) To accept applications from business owners on behalf of
38 themselves and their employees, spouses, and dependent children, as
39 subsidized or nonsubsidized enrollees, who reside in an area served by

1 the plan. The administrator may require all or the substantial
2 majority of the eligible employees of such businesses to enroll in the
3 plan and establish those procedures necessary to facilitate the orderly
4 enrollment of groups in the plan and into a managed health care system.
5 The administrator shall require that a business owner pay at least
6 fifty percent of the nonsubsidized premium cost of the plan on behalf
7 of each employee enrolled in the plan. Enrollment is limited to those
8 not eligible for medicare who wish to enroll in the plan and choose to
9 obtain the basic health care coverage and services from a managed care
10 system participating in the plan. The administrator shall adjust the
11 amount determined to be due on behalf of or from all such enrollees
12 whenever the amount negotiated by the administrator with the
13 participating managed health care system or systems is modified or the
14 administrative cost of providing the plan to such enrollees changes.

15 (11) To determine the rate to be paid to each participating managed
16 health care system in return for the provision of covered basic health
17 care services to enrollees in the system. Although the schedule of
18 covered basic health care services will be the same for similar
19 enrollees, the rates negotiated with participating managed health care
20 systems may vary among the systems. In negotiating rates with
21 participating systems, the administrator shall consider the
22 characteristics of the populations served by the respective systems,
23 economic circumstances of the local area, the need to conserve the
24 resources of the basic health plan trust account, and other factors the
25 administrator finds relevant.

26 ((+11+)) (12) To monitor the provision of covered services to
27 enrollees by participating managed health care systems in order to
28 assure enrollee access to good quality basic health care, to require
29 periodic data reports concerning the utilization of health care
30 services rendered to enrollees in order to provide adequate information
31 for evaluation, and to inspect the books and records of participating
32 managed health care systems to assure compliance with the purposes of
33 this chapter. In requiring reports from participating managed health
34 care systems, including data on services rendered enrollees, the
35 administrator shall endeavor to minimize costs, both to the managed
36 health care systems and to the ((administrator)) plan. The
37 administrator shall coordinate any such reporting requirements with
38 other state agencies, such as the insurance commissioner and the
39 department of health, to minimize duplication of effort.

1 (~~((12) To monitor the access that state residents have to adequate~~
2 ~~and necessary health care services, determine the extent of any unmet~~
3 ~~needs for such services or lack of access that may exist from time to~~
4 ~~time, and make such reports and recommendations to the legislature as~~
5 ~~the administrator deems appropriate.))~~)

6 (13) To evaluate the effects this chapter has on private employer-
7 based health care coverage and to take appropriate measures consistent
8 with state and federal statutes that will discourage the reduction of
9 such coverage in the state.

10 (14) To develop a program of proven preventive health measures and
11 to integrate it into the plan wherever possible and consistent with
12 this chapter.

13 (15) To provide, consistent with available ~~((resources, technical))~~
14 funding, assistance for rural ~~((health activities that endeavor to~~
15 ~~develop needed health care services in rural parts of the state))~~
16 residents, underserved populations, and persons of color.

17 **Sec. 213.** RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each
18 amended to read as follows:

19 ENROLLMENT. On and after July 1, 1988, the administrator shall
20 accept for enrollment applicants eligible to receive covered basic
21 health care services from the respective managed health care systems
22 which are then participating in the plan. ~~((The administrator shall~~
23 ~~not allow the total enrollment of those eligible for subsidies to~~
24 ~~exceed thirty thousand.))~~

25 Thereafter, total ~~((enrollment shall not exceed the number~~
26 ~~established by the legislature in any act appropriating funds to the~~
27 ~~plan.~~

28 Before July 1, 1988, the administrator shall endeavor to secure
29 participation contracts from managed health care systems in discrete
30 geographic areas within at least five congressional districts of the
31 state and in such manner as to allow residents of both urban and rural
32 areas access to enrollment in the plan. The administrator shall make
33 a special effort to secure agreements with health care providers in one
34 such area that meets the requirements set forth in RCW 70.47.060(4))
35 subsidized enrollment shall not result in expenditures that exceed the
36 total amount that has been made available by the legislature in any act
37 appropriating funds to the plan. To the extent that new funding is
38 appropriated for expansion, the administrator shall endeavor to secure

1 participation contracts from managed health care systems in geographic
2 areas of the state that are unserved by the plan at the time at which
3 the new funding is appropriated. In the selection of any such areas
4 the administrator shall take into account the levels and rates of
5 unemployment in different areas of the state, the need to provide basic
6 health care coverage to a population reasonably representative of the
7 portion of the state's population that lacks such coverage, and the
8 need for geographic, demographic, and economic diversity.

9 The administrator shall at all times closely monitor growth
10 patterns of enrollment so as not to exceed that consistent with the
11 orderly development of the plan as a whole, in any area of the state or
12 in any participating managed health care system. The annual or
13 biennial enrollment limitations derived from operation of the plan
14 under this section do not apply to nonsubsidized enrollees as defined
15 in RCW 70.47.020(5).

16 **B. EXPANDED MANAGED CARE FOR STATE EMPLOYEES**

17 **Sec. 214.** RCW 41.05.011 and 1990 c 222 s 2 are each amended to
18 read as follows:

19 DEFINITIONS. Unless the context clearly requires otherwise, the
20 definitions in this section shall apply throughout this chapter.

21 (1) "Administrator" means the administrator of the authority.

22 (2) "State purchased health care" or "health care" means medical
23 and health care, pharmaceuticals, and medical equipment purchased with
24 state and federal funds by the department of social and health
25 services, the department of health, the basic health plan, the state
26 health care authority, the department of labor and industries, the
27 department of corrections, the department of veterans affairs, and
28 local school districts.

29 (3) "Authority" means the Washington state health care authority.

30 (4) "Insuring entity" means an (~~insurance carrier as defined in~~
31 ~~chapter 48.21 or 48.22~~) insurer as defined in chapter 48.01 RCW, a
32 health care service contractor as defined in chapter 48.44 RCW, or a
33 health maintenance organization as defined in chapter 48.46 RCW. On
34 and after July 1, 1995, "insuring entity" means a certified health
35 plan, as defined in section 402 of this act.

36 (5) "Flexible benefit plan" means a benefit plan that allows
37 employees to choose the level of health care coverage provided and the

1 amount of employee contributions from among a range of choices offered
2 by the authority.

3 (6) "Employee" includes all full-time and career seasonal employees
4 of the state, whether or not covered by civil service; elected and
5 appointed officials of the executive branch of government, including
6 full-time members of boards, commissions, or committees; and includes
7 any or all part-time and temporary employees under the terms and
8 conditions established under this chapter by the authority; justices of
9 the supreme court and judges of the court of appeals and the superior
10 courts; and members of the state legislature or of the legislative
11 authority of any county, city, or town who are elected to office after
12 February 20, 1970. "Employee" also includes: (a) By October 1, 1995,
13 all employees of school districts. Between October 1, 1994, and
14 September 30, 1995, "employee" includes employees of those school
15 districts for whom the authority has undertaken the purchase of
16 insurance benefits. The transition to insurance benefits purchasing by
17 the authority may not disrupt existing insurance contracts between
18 school district employees and insurers. However, except to the extent
19 provided in RCW 28A.400.200, any such contract that provides for health
20 insurance benefits coverage after October 1, 1995, shall be void as of
21 that date if the contract was entered into, renewed, or extended after
22 July 1, 1993. Prior to October 1, 1994, "employee" includes employees
23 of a school district if the board of directors of the school district
24 seeks and receives the approval of the authority to provide any of its
25 insurance programs by contract with the authority; (b) employees of a
26 county, municipality, or other political subdivision of the state if
27 the legislative authority of the county, municipality, or other
28 political subdivision of the state seeks and receives the approval of
29 the authority to provide any of its insurance programs by contract with
30 the authority, as provided in RCW 41.04.205(~~(, and employees of a~~
31 ~~school district if the board of directors of the school district seeks~~
32 ~~and receives the approval of the authority to provide any of its~~
33 ~~insurance programs by contract with the authority as provided in RCW~~
34 ~~28A.400.350)); (c) employees of employee organizations representing
35 state civil service employees, at the option of each such employee
36 organization, and, effective October 1, 1995, employees of employee
37 organizations currently pooled with employees of school districts for
38 the purpose of purchasing insurance benefits, at the option of each
39 such employee organization.~~

1 (7) "Board" means the (~~state~~) public employees' benefits board
2 established under RCW 41.05.055.

3 **Sec. 215.** RCW 41.05.021 and 1990 c 222 s 3 are each amended to
4 read as follows:

5 HEALTH CARE AUTHORITY DUTIES. (1) The Washington state health care
6 authority is created within the executive branch. The authority shall
7 have an administrator appointed by the governor, with the consent of
8 the senate. The administrator shall serve at the pleasure of the
9 governor. The administrator may employ up to seven staff members, who
10 shall be exempt from chapter 41.06 RCW, and any additional staff
11 members as are necessary to administer this chapter. The primary
12 duties of the authority shall be to administer state employees'
13 insurance benefits (~~and to~~), study state-purchased health care
14 programs in order to maximize cost containment in these programs while
15 ensuring access to quality health care, and implement state
16 initiatives, joint purchasing strategies, and techniques for efficient
17 administration that have potential application to all state-purchased
18 health services. The authority's duties include, but are not limited
19 to, the following:

20 (~~(1)~~) (a) To administer a health care benefit program for
21 employees as specifically authorized in RCW 41.05.065 and in accordance
22 with the methods described in RCW 41.05.075, 41.05.140, and other
23 provisions of this chapter;

24 (~~(2)~~) (b) To analyze state-purchased health care programs and to
25 explore options for cost containment and delivery alternatives for
26 those programs that are consistent with the purposes of those programs,
27 including, but not limited to:

28 (~~(a)~~) (i) Creation of economic incentives for the persons for
29 whom the state purchases health care to appropriately utilize and
30 purchase health care services, including the development of flexible
31 benefit plans to offset increases in individual financial
32 responsibility;

33 (~~(b)~~) (ii) Utilization of provider arrangements that encourage
34 cost containment (~~and ensure access to quality care~~), including but
35 not limited to prepaid delivery systems, utilization review, and
36 prospective payment methods, and that ensure access to quality care,
37 including assuring reasonable access to local providers, especially for
38 employees residing in rural areas;

1 ~~((e))~~ (iii) Coordination of state agency efforts to purchase
2 drugs effectively as provided in RCW 70.14.050;

3 ~~((d))~~ (iv) Development of recommendations and methods for
4 purchasing medical equipment and supporting services on a volume
5 discount basis; and

6 ~~((e))~~ (v) Development of data systems to obtain utilization data
7 from state-purchased health care programs in order to identify cost
8 centers, utilization patterns, provider and hospital practice patterns,
9 and procedure costs, utilizing the information obtained pursuant to RCW
10 41.05.031;

11 ~~((3))~~ (c) To analyze areas of public and private health care
12 interaction;

13 ~~((4))~~ (d) To provide information and technical and administrative
14 assistance to the board;

15 ~~((5))~~ (e) To review and approve or deny applications from
16 counties, municipalities, and other political subdivisions of the
17 state(~~(, and school districts)~~) to provide state-sponsored insurance or
18 self-insurance programs to their employees in accordance with the
19 provisions of RCW 41.04.205 (~~(and 28A.400.350)~~), setting the premium
20 contribution for approved groups as outlined in RCW 41.05.050;

21 ~~((6))~~ (f) To appoint a health care policy technical advisory
22 committee as required by RCW 41.05.150; and

23 ~~((7))~~ (g) To promulgate and adopt rules consistent with this
24 chapter as described in RCW 41.05.160.

25 (2) The public employees' benefits board shall implement strategies
26 to promote managed competition among employee health benefit plans by
27 January 1, 1995, including but not limited to:

28 (a) Standardizing the benefit package;

29 (b) Soliciting competitive bids for the benefit package;

30 (c) Limiting the state's contribution to a percent of the lowest
31 priced sealed bid of a qualified plan within a geographical area. If
32 the state's contribution is less than one hundred percent of the lowest
33 priced sealed bid, employee financial contributions shall be structured
34 on a sliding-scale basis related to household income;

35 (d) Monitoring the impact of the approach under this subsection
36 with regards to: Efficiencies in health service delivery, cost shifts
37 to subscribers, access to and choice of managed care plans state-wide,
38 and quality of health services. The health care authority shall also
39 advise on the value of administering a benchmark employer-managed plan

1 to promote competition among managed care plans. The health care
2 authority shall report its findings and recommendations to the
3 legislature by January 1, 1997.

4 **Sec. 216.** RCW 41.05.050 and 1988 c 107 s 18 are each amended to
5 read as follows:

6 FERRY EMPLOYEES. (1) Every department, division, or separate
7 agency of state government, and such county, municipal, or other
8 political subdivisions as are covered by this chapter, shall provide
9 contributions to insurance and health care plans for its employees and
10 their dependents, the content of such plans to be determined by the
11 authority. Contributions, paid by the county, the municipality, or
12 other political subdivision for their employees, shall include an
13 amount determined by the authority to pay such administrative expenses
14 of the authority as are necessary to administer the plans for employees
15 of those groups. All such contributions will be paid into the
16 ((state)) public employees' health insurance account.

17 (2) The contributions of any department, division, or separate
18 agency of the state government, and such county, municipal, or other
19 political subdivisions as are covered by this chapter, shall be set by
20 the authority, subject to the approval of the governor for availability
21 of funds as specifically appropriated by the legislature for that
22 purpose. ((However,)) Insurance and health care contributions for
23 ferry employees shall be governed by RCW 47.64.270 until December 31,
24 1996. On and after January 1, 1997, ferry employees shall enroll with
25 certified health plans under chapter . . . , Laws of 1993 (this act).

26 (3) The administrator with the assistance of the ((state)) public
27 employees' benefits board shall survey private industry and public
28 employers in the state of Washington to determine the average employer
29 contribution for group insurance programs under the jurisdiction of the
30 authority. Such survey shall be conducted during each even-numbered
31 year but may be conducted more frequently. The survey shall be
32 reported to the authority for its use in setting the amount of the
33 recommended employer contribution to the employee insurance benefit
34 program covered by this chapter. The authority shall transmit a
35 recommendation for the amount of the employer contribution to the
36 governor and the director of financial management for inclusion in the
37 proposed budgets submitted to the legislature.

1 **Sec. 217.** RCW 41.05.055 and 1989 c 324 s 1 are each amended to
2 read as follows:

3 PUBLIC EMPLOYEES' BENEFITS BOARD--SCHOOL DISTRICT EMPLOYEES. (1)
4 The ~~((state))~~ public employees' benefits board is created within the
5 authority. The function of the board is to design and approve
6 insurance benefit plans for state employees and school district
7 employees.

8 (2) Effective January 1, 1995, the board shall be composed of
9 ~~((seven))~~ nine members appointed by the governor as follows:

10 (a) ~~((Three))~~ Two representatives of state employees, ~~((one of whom~~
11 ~~shall represent an employee association certified as exclusive~~
12 ~~representative of at least one bargaining unit of classified~~
13 ~~employees,))~~ one of whom shall represent an employee union certified as
14 exclusive representative of at least one bargaining unit of classified
15 employees, and one of whom is retired, is covered by a program under
16 the jurisdiction of the board, and represents an organized group of
17 retired public employees;

18 (b) Two representatives of school district employees, one of whom
19 shall represent an association of school employees and one of whom is
20 retired, and represents an organized group of retired school employees;

21 ~~((Three))~~ (c) Four members with experience in health benefit
22 management and cost containment; and

23 ~~((e))~~ (d) The administrator.

24 Prior to January 1, 1995, the composition of the public employees
25 benefits board shall reflect its composition on January 1, 1993.

26 (3) The governor shall appoint the initial members of the board to
27 staggered terms not to exceed four years. Members appointed thereafter
28 shall serve two-year terms. Members of the board shall be compensated
29 in accordance with RCW 43.03.250 and shall be reimbursed for their
30 travel expenses while on official business in accordance with RCW
31 43.03.050 and 43.03.060. The board shall prescribe rules for the
32 conduct of its business. The administrator shall serve as chair of the
33 board. Meetings of the board shall be at the call of the chair.

34 **Sec. 218.** RCW 41.05.065 and 1988 c 107 s 8 are each amended to
35 read as follows:

36 EMPLOYEE BENEFIT PLANS--STANDARDS. (1) The board shall study all
37 matters connected with the provision of health care coverage, life
38 insurance, liability insurance, accidental death and dismemberment

1 insurance, and disability income insurance or any of, or a combination
2 of, the enumerated types of insurance for employees and their
3 dependents on the best basis possible with relation both to the welfare
4 of the employees and to the state(~~(:—PROVIDED, That)~~), however
5 liability insurance shall not be made available to dependents.

6 (2) The (~~state~~) public employees' benefits board shall develop
7 employee benefit plans that include comprehensive health care benefits
8 for all employees. In developing these plans, the board shall consider
9 the following elements:

10 (a) Methods of maximizing cost containment while ensuring access to
11 quality health care;

12 (b) Development of provider arrangements that encourage cost
13 containment and ensure access to quality care, including but not
14 limited to prepaid delivery systems and prospective payment methods;

15 (c) Wellness incentives that focus on proven strategies, such as
16 smoking cessation, exercise, (~~and~~) automobile and motorcycle safety,
17 blood cholesterol reduction, and nutrition education;

18 (d) Utilization review procedures including, but not limited to
19 prior authorization of services, hospital inpatient length of stay
20 review, requirements for use of outpatient surgeries and second
21 opinions for surgeries, review of invoices or claims submitted by
22 service providers, and performance audit of providers; (~~and~~)

23 (e) Effective coordination of benefits;

24 (f) Minimum standards for insuring entities; and

25 (g) Minimum scope and content of standard benefit plans to be
26 offered to enrollees participating in the employee health benefit
27 plans. On and after July 1, 1995, the uniform benefits package shall
28 constitute the minimum level of health benefits offered to employees.
29 To maintain the comprehensive nature of employee health care benefits,
30 employee eligibility criteria related to the number of hours worked and
31 the benefits provided to employees shall be substantially equivalent to
32 the state employees' health benefits plan and eligibility criteria in
33 effect on January 1, 1993.

34 (3) The board shall design benefits and determine the terms and
35 conditions of employee participation and coverage, including
36 establishment of eligibility criteria.

37 (4) The board shall attempt to achieve enrollment of all employees
38 and retirees in managed health care systems by July 1994.

1 The board may authorize premium contributions for an employee and
2 the employee's dependents in a manner that encourages the use of cost-
3 efficient managed health care systems. (~~(Such authorization shall~~
4 ~~require a vote of five members of the board for approval.)~~)

5 (5) Employees (~~(may)~~) shall choose participation in (~~(only)~~) one of
6 the health care benefit plans developed by the board.

7 (6) The board shall review plans proposed by insurance carriers
8 that desire to offer property insurance and/or accident and casualty
9 insurance to state employees through payroll deduction. The board may
10 approve any such plan for payroll deduction by carriers holding a valid
11 certificate of authority in the state of Washington and which the board
12 determines to be in the best interests of employees and the state. The
13 board shall promulgate rules setting forth criteria by which it shall
14 evaluate the plans.

15 **Sec. 219.** RCW 41.05.120 and 1991 sp.s. c 13 s 100 are each amended
16 to read as follows:

17 PUBLIC EMPLOYEES' INSURANCE ACCOUNT. (1) The (~~(state)~~) public
18 employees' insurance account is hereby established in the custody of
19 the state treasurer, to be used by the administrator for the deposit of
20 contributions, reserves, dividends, and refunds, and for payment of
21 premiums for employee insurance benefit contracts. Moneys from the
22 account shall be disbursed by the state treasurer by warrants on
23 vouchers duly authorized by the administrator.

24 (2) The state treasurer and the state investment board may invest
25 moneys in the (~~(state)~~) public employees' insurance account. All such
26 investments shall be in accordance with RCW 43.84.080 or 43.84.150,
27 whichever is applicable. The administrator shall determine whether the
28 state treasurer or the state investment board or both shall invest
29 moneys in the (~~(state)~~) public employees' insurance account.

30 **Sec. 220.** RCW 41.05.140 and 1988 c 107 s 12 are each amended to
31 read as follows:

32 PUBLIC EMPLOYEES' INSURANCE RESERVE FUND. (1) The authority may
33 self-fund or self-insure for public employees' benefits plans, but
34 shall also enter into other methods of providing insurance coverage for
35 insurance programs under its jurisdiction except property and casualty
36 insurance. The authority shall contract for payment of claims or other
37 administrative services for programs under its jurisdiction. If a

1 program does not require the prepayment of reserves, the authority
2 shall establish such reserves within a reasonable period of time for
3 the payment of claims as are normally required for that type of
4 insurance under an insured program. Reserves established by the
5 authority shall be held in a separate trust fund by the state treasurer
6 and shall be known as the ((state)) public employees' insurance reserve
7 fund. The state investment board shall act as the investor for the
8 funds and, except as provided in RCW 43.33A.160, one hundred percent of
9 all earnings from these investments shall accrue directly to the
10 ((state)) public employees' insurance reserve fund.

11 (2) Any savings realized as a result of a program created under
12 this section shall not be used to increase benefits unless such use is
13 authorized by statute.

14 (3) Any program created under this section shall be subject to the
15 examination requirements of chapter 48.03 RCW as if the program were a
16 domestic insurer. In conducting an examination, the commissioner shall
17 determine the adequacy of the reserves established for the program.

18 (4) The authority shall keep full and adequate accounts and records
19 of the assets, obligations, transactions, and affairs of any program
20 created under this section.

21 (5) The authority shall file a quarterly statement of the financial
22 condition, transactions, and affairs of any program created under this
23 section in a form and manner prescribed by the insurance commissioner.
24 The statement shall contain information as required by the commissioner
25 for the type of insurance being offered under the program. A copy of
26 the annual statement shall be filed with the speaker of the house of
27 representatives and the president of the senate.

28 NEW SECTION. **Sec. 221.** A new section is added to chapter 41.05
29 RCW to read as follows:

30 MEDICARE SUPPLEMENTAL BENEFITS. The administrator, in consultation
31 with the public employees' benefits board, shall design a self-insured
32 medicare supplemental insurance plan for retired and disabled employees
33 eligible for medicare. For the purpose of determining the appropriate
34 scope of the self-funded medicare supplemental plan, the administrator
35 shall consider the differences in the scope of health services
36 available under the uniform benefits package and the medicare program.
37 The proposed plan shall be submitted to appropriate committees of the
38 legislature by December 1, 1993.

1 NEW SECTION. **Sec. 222.** A new section is added to chapter 41.05
2 RCW to read as follows:

3 MEDICARE SUPPLEMENTAL BENEFITS. Notwithstanding any other
4 provisions of this title or rules or procedures adopted by the
5 authority, the authority shall make available to retired or disabled
6 employees who are eligible for medicare at least two medicare
7 supplemental insurance policies that conform to the requirements of
8 chapter 48.66 RCW. One policy shall include coverage for prescription
9 drugs. The policies shall be chosen in consultation with the public
10 employees' benefits board. These policies shall be made available to
11 retired or disabled employees, or employees of county, municipal, or
12 other political subdivisions eligible for coverage available under the
13 authority. All offerings shall be made available not later than
14 January 1, 1994.

15 NEW SECTION. **Sec. 223.** A new section is added to chapter 41.05
16 RCW to read as follows:

17 MEDICARE SUPPLEMENTAL BENEFITS. If a waiver of the medicare
18 statute, Title XVIII of the federal social security act, sufficient to
19 meet the requirements of chapter . . . , Laws of 1993 (this act) is not
20 granted on or before January 1, 1995, the medicare supplemental
21 insurance policies authorized under section 222 of this act shall be
22 made available to any resident of the state eligible for medicare
23 benefits. Except for those retired state or school district employees
24 eligible to purchase medicare supplemental benefits through the
25 authority, persons purchasing a medicare supplemental insurance policy
26 under this section shall be required to pay the full cost of any such
27 policy.

28 **Sec. 224.** RCW 47.64.270 and 1988 c 107 s 21 are each amended to
29 read as follows:

30 FERRY EMPLOYEES--ENROLLMENT IN CERTIFIED HEALTH PLANS. Until
31 December 31, 1996, absent a collective bargaining agreement to the
32 contrary, the department of transportation shall provide contributions
33 to insurance and health care plans for ferry system employees and
34 dependents, as determined by the state health care authority, under
35 chapter 41.05 RCW((-)); and the ferry system management and employee
36 organizations may collectively bargain for other insurance and health
37 care plans, and employer contributions may exceed that of other state

1 agencies as provided in RCW 41.05.050, subject to RCW 47.64.180. On
2 January 1, 1997, ferry employees shall enroll in certified health plans
3 under the provisions of chapter . . . , Laws of 1993 (this act). To the
4 extent that ferry employees by bargaining unit have absorbed the
5 required offset of wage increases by the amount that the employer's
6 contribution for employees' and dependents' insurance and health care
7 plans exceeds that of other state general government employees in the
8 1985-87 fiscal biennium, employees shall not be required to absorb a
9 further offset except to the extent the differential between employer
10 contributions for those employees and all other state general
11 government employees increases during any subsequent fiscal biennium.
12 If such differential increases in the 1987-89 fiscal biennium or the
13 1985-87 offset by bargaining unit is insufficient to meet the required
14 deduction, the amount available for compensation shall be reduced by
15 bargaining unit by the amount of such increase or the 1985-87 shortage
16 in the required offset. Compensation shall include all wages and
17 employee benefits.

18 **Sec. 225.** RCW 28A.400.200 and 1990 1st ex.s. c 11 s 2 and 1990 c
19 33 s 381 are each reenacted and amended to read as follows:

20 SCHOOL DISTRICT EMPLOYEES--EMPLOYER CONTRIBUTIONS. (1) Every
21 school district board of directors shall fix, alter, allow, and order
22 paid salaries and compensation for all district employees in
23 conformance with this section.

24 (2)(a) Salaries for certificated instructional staff shall not be
25 less than the salary provided in the appropriations act in the state-
26 wide salary allocation schedule for an employee with a baccalaureate
27 degree and zero years of service; and

28 (b) Salaries for certificated instructional staff with a masters
29 degree shall not be less than the salary provided in the appropriations
30 act in the state-wide salary allocation schedule for an employee with
31 a masters degree and zero years of service;

32 (3)(a) The actual average salary paid to basic education
33 certificated instructional staff shall not exceed the district's
34 average basic education certificated instructional staff salary used
35 for the state basic education allocations for that school year as
36 determined pursuant to RCW 28A.150.410.

37 (b) Fringe benefit contributions for basic education certificated
38 instructional staff shall be included as salary under (a) of this

1 subsection only to the extent that the district's actual average
2 benefit contribution exceeds the ~~((greater of: (i) The formula amount
3 for insurance benefits))~~ amount of the insurance benefits allocation
4 provided per certificated instructional staff unit in the state
5 operating appropriations act in effect at the time the compensation is
6 payable~~((; or (ii) the actual average amount provided by the school
7 district in the 1986-87 school year))~~. For purposes of this section,
8 fringe benefits shall not include payment for unused leave for illness
9 or injury under RCW 28A.400.210~~((, or))~~; employer contributions for old
10 age survivors insurance, workers' compensation, unemployment
11 compensation, and retirement benefits under the Washington state
12 retirement system; or employer contributions for health benefits in
13 excess of the insurance benefits allocation provided per certificated
14 instructional staff unit in the state operating appropriations act in
15 effect at the time the compensation is payable. A school district may
16 not use state funds to provide employer contributions for such excess
17 health benefits.

18 (c) Salary and benefits for certificated instructional staff in
19 programs other than basic education shall be consistent with the salary
20 and benefits paid to certificated instructional staff in the basic
21 education program.

22 (4) Salaries and benefits for certificated instructional staff may
23 exceed the limitations in subsection (3) of this section only by
24 separate contract for additional time, additional responsibilities, or
25 incentives. Supplemental contracts shall not cause the state to incur
26 any present or future funding obligation. Supplemental contracts shall
27 be subject to the collective bargaining provisions of chapter 41.59 RCW
28 and the provisions of RCW 28A.405.240, shall not exceed one year, and
29 if not renewed shall not constitute adverse change in accordance with
30 RCW 28A.405.300 through 28A.405.380. No district may enter into a
31 supplemental contract under this subsection for the provision of
32 services which are a part of the basic education program required by
33 Article IX, section 3 of the state Constitution.

34 (5) Employee benefit plans offered by any district shall comply
35 with RCW 28A.400.350 and 28A.400.275 and 28A.400.280.

36 **Sec. 226.** RCW 28A.400.350 and 1990 1st ex.s. c 11 s 3 and 1990 c
37 74 s 1 are each reenacted and amended to read as follows:

1 SCHOOL DISTRICTS--HEALTH CARE COVERAGE ONLY BY CONTRACTS WITH THE
2 STATE HEALTH CARE AUTHORITY. (1) The board of directors of any of the
3 state's school districts may make available liability, life, health,
4 health care, accident, disability and salary protection or insurance or
5 any one of, or a combination of the enumerated types of insurance, or
6 any other type of insurance or protection, for the members of the
7 boards of directors, the students, and employees of the school
8 district, and their dependents. Such coverage may be provided by
9 contracts with private carriers, with the state health care authority
10 after July 1, 1990, pursuant to the approval of the authority
11 administrator, or through self-insurance or self-funding pursuant to
12 chapter 48.62 RCW, or in any other manner authorized by law. Except
13 for health benefits purchased with nonstate funds as provided in RCW
14 28A.400.200, effective on and after October 1, 1995, health care
15 coverage, life insurance, liability insurance, accidental death and
16 dismemberment insurance, and disability income insurance shall be
17 provided only by contracts with the state health care authority.

18 (2) Whenever funds are available for these purposes the board of
19 directors of the school district may contribute all or a part of the
20 cost of such protection or insurance for the employees of their
21 respective school districts and their dependents. The premiums on such
22 liability insurance shall be borne by the school district.

23 After October 1, 1990, school districts may not contribute to any
24 employee protection or insurance other than liability insurance unless
25 the district's employee benefit plan conforms to RCW 28A.400.275 and
26 28A.400.280.

27 (3) For school board members and students, the premiums due on such
28 protection or insurance shall be borne by the assenting school board
29 member or student(~~(:—PROVIDED, That)~~). The school district may
30 contribute all or part of the costs, including the premiums, of life,
31 health, health care, accident or disability insurance which shall be
32 offered to all students participating in interschool activities on the
33 behalf of or as representative of their school or school district. The
34 school district board of directors may require any student
35 participating in extracurricular interschool activities to, as a
36 condition of participation, document evidence of insurance or purchase
37 insurance that will provide adequate coverage, as determined by the
38 school district board of directors, for medical expenses incurred as a
39 result of injury sustained while participating in the extracurricular

1 activity. In establishing such a requirement, the district shall adopt
2 regulations for waiving or reducing the premiums of such coverage as
3 may be offered through the school district to students participating in
4 extracurricular activities, for those students whose families, by
5 reason of their low income, would have difficulty paying the entire
6 amount of such insurance premiums. The district board shall adopt
7 regulations for waiving or reducing the insurance coverage requirements
8 for low-income students in order to assure such students are not
9 prohibited from participating in extracurricular interschool
10 activities.

11 (4) All contracts for insurance or protection written to take
12 advantage of the provisions of this section shall provide that the
13 beneficiaries of such contracts may utilize on an equal participation
14 basis the services of those practitioners licensed pursuant to chapters
15 18.22, 18.25, 18.53, 18.57, and 18.71 RCW.

16 **C. CONSOLIDATED STATE HEALTH CARE PURCHASING AGENT**

17 NEW SECTION. **Sec. 227.** A new section is added to Title 43 RCW to
18 read as follows:

19 STATE HEALTH SERVICES AGENT. (1) The health care authority is
20 hereby designated as the single state agent for purchasing health
21 services.

22 (2) On and after July 1, 1995, at least the following state-
23 purchased health services programs shall be merged into a single,
24 community-rated risk pool: The basic health plan; health benefits for
25 employees of school districts; and health benefits for state employees.
26 Until that date, in purchasing health services, the health care
27 authority shall maintain separate risk pools for each of the programs
28 in this subsection. The administrator may develop mechanisms to ensure
29 that the cost of comparable benefits packages does not vary widely
30 across the risk pools. At the earliest opportunity the governor shall
31 seek necessary federal waivers and state legislation to place the
32 medical and acute care components of the medical assistance program,
33 the limited casualty program, and the medical care services program of
34 the department of social and health services in this single risk pool.
35 Long-term care services that are provided under the medical assistance
36 program shall not be placed in the single risk pool until such services
37 have been added to the uniform benefits package. On or before January

1 1, 1997, the governor shall submit necessary legislation to place the
2 purchasing of health benefits for persons incarcerated in institutions
3 administered by the department of corrections into the single
4 community-rated risk pool effective on and after July 1, 1997.

5 (3) At a minimum, and regardless of other legislative enactments,
6 the state health services purchasing agent shall:

7 (a) Require that a public agency that provides subsidies for a
8 substantial portion of services now covered under the basic health plan
9 or a uniform benefits package as adopted by the Washington health
10 services commission as provided in section 449 of this act, use uniform
11 eligibility processes, insofar as may be possible, and ensure that
12 multiple eligibility determinations are not required;

13 (b) Require that a health care provider or a health care facility
14 that receives funds from a public program provide care to state
15 residents receiving a state subsidy who may wish to receive care from
16 them consistent with the provisions of chapter ..., Laws of 1993 (this
17 act), and that a health maintenance organization, health care service
18 contractor, insurer, or certified health plan that receives funds from
19 a public program accept enrollment from state residents receiving a
20 state subsidy who may wish to enroll with them under the provisions of
21 chapter ..., Laws of 1993 (this act);

22 (c) Strive to integrate purchasing for all publicly sponsored
23 health services in order to maximize the cost control potential and
24 promote the most efficient methods of financing and coordinating
25 services;

26 (d) Annually suggest changes in state and federal law and rules to
27 bring all publicly funded health programs in compliance with the goals
28 and intent of chapter . . . , Laws of 1993 (this act);

29 (e) Consult regularly with the governor, the legislature, and state
30 agency directors whose operations are affected by the implementation of
31 this section.

32 NEW SECTION. **Sec. 228.** A new section is added to chapter 41.05
33 RCW to read as follows:

34 WASHINGTON STATE GROUP PURCHASING ASSOCIATION. (1) The Washington
35 state group purchasing association is established for the purpose of
36 coordinating and enhancing the health care purchasing power of the
37 groups identified in subsection (2) of this section. The purchasing
38 association shall be administered by the administrator.

1 (2) The following organizations or entities may seek the approval
2 of the administrator for membership in the purchasing association:

3 (a) Private nonprofit human services provider organizations under
4 contract with state agencies, on behalf of their employees and their
5 employees' spouses and dependent children;

6 (b) Individuals providing in-home long-term care services to
7 persons whose care is financed in whole or in part through the medical
8 assistance personal care or community options program entry system
9 program as provided in chapter 74.09 RCW, or the chore services
10 program, as provided in chapter 74.08 RCW, on behalf of themselves and
11 their spouses and dependent children;

12 (c) Owners and operators of child day care centers and family child
13 care homes licensed under chapter 74.15 RCW and of preschool or other
14 child care programs exempted from licensing under chapter 74.15 RCW on
15 behalf of themselves and their employees and employees' spouses and
16 dependent children; and

17 (d) Foster parents contracting with the department of social and
18 health services under chapter 74.13 RCW and licensed under chapter
19 74.15 RCW on behalf of themselves and their spouses and dependent
20 children.

21 (3) In administering the purchasing association, the administrator
22 shall:

23 (a) Negotiate and enter into contracts on behalf of the purchasing
24 association's members in conjunction with its contracting and
25 purchasing activities for employee benefits plans under RCW 41.05.075.
26 In negotiating and contracting with insuring entities on behalf of
27 employees and purchasing association members, two distinct pools shall
28 be maintained.

29 (b) Review and approve or deny applications from entities seeking
30 membership in the purchasing association:

31 (i) The administrator may require all or the substantial majority
32 of the employees of the organizations or entities listed in subsection
33 (2) of this section to enroll in the purchasing association.

34 (ii) The administrator shall require, that as a condition of
35 membership in the purchasing association, an entity or organization
36 listed in subsection (2) of this section that employs individuals pay
37 at least fifty percent of the cost of the health insurance coverage for
38 each employee enrolled in the purchasing association.

1 (iii) In offering and administering the purchasing association, the
2 administrator may not discriminate against individuals or groups based
3 on age, gender, geographic area, industry, or medical history.

4 (4) On and after July 1, 1995, the uniform benefits package and
5 schedule of premiums and point of service cost-sharing adopted and from
6 time to time revised by the health services commission pursuant to
7 chapter . . ., Laws of 1993 (this act) shall be applicable to the
8 association.

9 (5) The administrator shall adopt preexisting condition coverage
10 provisions for the association as provided in sections 283 through 286
11 of this act.

12 (6) Premiums charged to purchasing association members shall
13 include the authority's reasonable administrative and marketing costs.
14 Purchasing association members may not receive any subsidy from the
15 state for the purchase of health insurance coverage through the
16 association.

17 (7)(a) The Washington state group purchasing association account is
18 established in the custody of the state treasurer, to be used by the
19 administrator for the deposit of premium payments from individuals and
20 entities described in subsection (2) of this section, and for payment
21 of premiums for benefit contracts entered into on behalf of the
22 purchasing association's participants and operating expenses incurred
23 by the authority in the administration of benefit contracts under this
24 section. Moneys from the account shall be disbursed by the state
25 treasurer by warrants on vouchers duly authorized by the administrator.

26 (b) Disbursements from the account are not subject to
27 appropriations, but shall be subject to the allotment procedure
28 provided under chapter 43.88 RCW.

29 NEW SECTION. **Sec. 229.** A new section is added to chapter 41.05
30 RCW to read as follows:

31 **MARKETING PLAN.** The administrator shall develop a marketing plan
32 for the basic health plan and the Washington state group purchasing
33 association. The plan shall be targeted to individuals and entities
34 eligible to enroll in the two programs and provide clear and
35 understandable explanations of the programs and enrollment procedures.
36 The plan also shall incorporate special efforts to reach communities
37 and people of color.

1 NEW SECTION. **Sec. 230.** WASHINGTON STATE GROUP PURCHASING
2 ASSOCIATION--REPEAL. The following acts or parts of acts, as now
3 existing or hereafter amended, are each repealed, effective June 30,
4 1998:

5 (1) RCW 41.05.____ and 1993 c ____ s 228 (section 228 of this act);
6 and

7 (2) RCW 41.05.____ and 1993 c ____ s 229 (section 229 of this act).

8 **Sec. 231.** RCW 74.09.055 and 1982 c 201 s 19 are each amended to
9 read as follows:

10 The department is authorized to establish copayment, deductible, or
11 coinsurance requirements for recipients of any medical programs defined
12 in RCW 74.09.010 (~~but shall not establish copayment, deductible or~~
13 ~~coinsurance requirements for legend drugs as defined in RCW 69.41.210,~~
14 ~~unless required by federal law~~)).

15 NEW SECTION. **Sec. 232.** TRANSFER OF AUTHORITY TO PURCHASE SERVICES
16 FROM COMMUNITY HEALTH CENTERS. (1) State general funds appropriated to
17 the department of health for the purposes of funding community health
18 centers to provide primary health and dental care services, migrant
19 health services, and maternity health care services shall be
20 transferred to the state health care authority. Any related
21 administrative funds expended by the department of health for this
22 purpose shall also be transferred to the health care authority. The
23 health care authority shall exclusively expend these funds through
24 contracts with community health centers to provide primary health and
25 dental care services, migrant health services, and maternity health
26 care services. The administrator of the health care authority shall
27 establish requirements necessary to assure community health centers
28 provide quality health care services that are appropriate and effective
29 and are delivered in a cost-efficient manner. The administrator shall
30 further assure that community health centers have appropriate referral
31 arrangements for acute care and medical specialty services not provided
32 by the community health centers.

33 (2) To further the intent of chapter . . . , Laws of 1993 (this
34 act), the health care authority, in consultation with the department of
35 health, shall evaluate the organization and operation of the federal
36 and state-funded community health centers and other not-for-profit
37 health care organizations and propose recommendations to the health

1 services commission and the health policy committees of the legislature
2 by November 30, 1994, that identify changes to permit community health
3 centers and other not-for-profit health care organizations to form
4 certified health plans or other innovative health care delivery
5 arrangements that help ensure access to primary health care services
6 consistent with the purposes of chapter . . . , Laws of 1993 (this act).

7 (3) The authority, in consultation with the department of health,
8 shall work with community and migrant health clinics and other
9 providers of care to underserved populations, to ensure that the number
10 of people of color and underserved people receiving access to managed
11 care is expanded in proportion to need, based upon demographic data.

12 **D. HEALTH CARE PROVIDER CONFLICT OF INTEREST STANDARDS**

13 **Sec. 233.** RCW 19.68.010 and 1973 1st ex.s. c 26 s 1 are each
14 amended to read as follows:

15 FINANCIAL INTEREST IN HEALTH CARE FACILITIES--LIST OF ALTERNATIVE
16 FACILITIES TO BE PROVIDED. It shall be unlawful for any person, firm,
17 corporation or association, whether organized as a cooperative, or for
18 profit or nonprofit, to pay, or offer to pay or allow, directly or
19 indirectly, to any person licensed by the state of Washington to engage
20 in the practice of medicine and surgery, drugless treatment in any
21 form, dentistry, or pharmacy and it shall be unlawful for such person
22 to request, receive or allow, directly or indirectly, a rebate, refund,
23 commission, unearned discount or profit by means of a credit or other
24 valuable consideration in connection with the referral of patients to
25 any person, firm, corporation or association, or in connection with the
26 furnishings of medical, surgical or dental care, diagnosis, treatment
27 or service, on the sale, rental, furnishing or supplying of clinical
28 laboratory supplies or services of any kind, drugs, medication, or
29 medical supplies, or any other goods, services or supplies prescribed
30 for medical diagnosis, care or treatment(~~(:—PROVIDED, That)~~).
31 Ownership of a financial interest in any firm, corporation or
32 association which furnishes any kind of clinical laboratory or other
33 services prescribed for medical, surgical, or dental diagnosis shall
34 not be prohibited under this section where (1) the referring
35 practitioner affirmatively discloses to the patient in writing, the
36 fact that such practitioner has a financial interest in such firm,
37 corporation, or association; and (2) the referring practitioner

1 provides the patient with a list of effective alternative facilities,
2 informs the patient that he or she has the option to use one of the
3 alternative facilities, and assures the patient that he or she will not
4 be treated differently by the referring practitioner if the patient
5 chooses one of the alternative facilities.

6 Any person violating the provisions of this section is guilty of a
7 misdemeanor.

8 **E. PUBLIC HEALTH FINANCING AND GOVERNANCE**

9 **Sec. 234.** RCW 70.05.010 and 1967 ex.s. c 51 s 1 are each amended
10 to read as follows:

11 DEFINITIONS--DEPARTMENT OF HEALTH. For the purposes of chapters
12 70.05 and 70.46 RCW (~~(and RCW 70.46.020 through 70.46.090)~~) and unless
13 the context thereof clearly indicates to the contrary:

14 (1) "Local health departments" means the (~~(city, town,)~~) county or
15 district which provides public health services to persons within the
16 area;

17 (2) "Local health officer" means the legally qualified physician
18 who has been appointed as the health officer for the (~~(city, town,)~~)
19 county or district public health department;

20 (3) "Local board of health" means the (~~(city, town,)~~) county or
21 district board of health.

22 (4) "Health district" means (~~(all territory encompassed within a~~
23 ~~single county and all cities and towns therein except cities with a~~
24 ~~population of over one hundred thousand, or)) all the territory~~
25 consisting of one or more counties (~~(and all the cities and towns in~~
26 ~~all of the combined counties except cities of over one hundred thousand~~
27 ~~population which have been combined and)) organized pursuant to the~~
28 provisions of chapters 70.05 and 70.46 RCW (~~(and RCW 70.46.020 through~~
29 ~~70.46.090: PROVIDED, That cities with a population of over one hundred~~
30 ~~thousand may be included in a health district as provided in RCW~~
31 ~~70.46.040))~~).

32 (5) "Department" means the department of health.

33 **Sec. 235.** RCW 70.05.030 and 1967 ex.s. c 51 s 3 are each amended
34 to read as follows:

35 LOCAL BOARD OF HEALTH--COUNTIES WITHOUT HOME RULE CHARTER--
36 JURISDICTION. In counties without a home rule charter, the board of

1 county commissioners (~~(of each and every county in this state, except~~
2 ~~where such county is a part of a health district or is purchasing~~
3 ~~services under a contract as authorized by chapter 70.05 RCW and RCW~~
4 ~~70.46.020 through 70.46.090,)) shall constitute the local board of
5 health (~~(for such county, and said local board of health's~~
6 ~~jurisdiction)), unless the county is part of a health district pursuant
7 to chapter 70.46 RCW. The jurisdiction of the local board of health
8 shall be coextensive with the boundaries of said county(~~(, except that~~
9 ~~nothing herein contained shall give said board jurisdiction in cities~~
10 ~~of over one hundred thousand population or in such other cities and~~
11 ~~towns as are providing health services which meet health standards~~
12 ~~pursuant to RCW 70.46.090)).~~~~~~

13 **Sec. 236.** RCW 70.05.040 and 1984 c 25 s 1 are each amended to read
14 as follows:

15 LOCAL BOARD OF HEALTH--VACANCIES. The local board of health shall
16 elect a (~~(chairman))~~ chair and may appoint an administrative officer.
17 A local health officer shall be appointed pursuant to RCW 70.05.050.
18 Vacancies on the local board of health shall be filled by appointment
19 within thirty days and made in the same manner as was the original
20 appointment. At the first meeting of the local board of health, the
21 members shall elect a (~~(chairman))~~ chair to serve for a period of one
22 year. (~~(In home rule charter counties that have a local board of~~
23 ~~health established under RCW 70.05.050, the administrative officer may~~
24 ~~be appointed by the official designated under the county's charter.))~~

25 NEW SECTION. **Sec. 237.** A new section is added to chapter 70.05
26 RCW to read as follows:

27 HOME RULE CHARTER--LOCAL BOARD OF HEALTH. In counties with a home
28 rule charter, the county legislative authority shall establish a local
29 board of health and may prescribe the membership and selection process
30 for the board. The jurisdiction of the local board of health shall be
31 coextensive with the boundaries of the county. The local health
32 officer, as described in RCW 70.05.050, shall be appointed by the
33 official designated under the provisions of the county charter. The
34 same official designated under the provisions of the county charter may
35 appoint an administrative officer, as described in RCW 70.05.045.

1 **Sec. 238.** RCW 70.05.050 and 1984 c 25 s 5 are each amended to read
2 as follows:

3 LOCAL HEALTH OFFICER. (~~Each local board of health, other than~~
4 ~~boards which are established under RCW 70.05.030 and which are located~~
5 ~~in counties having home rule charters, shall appoint a local health~~
6 ~~officer. In home rule charter counties which have a local board of~~
7 ~~health established under RCW 70.05.030, the local health officer shall~~
8 ~~be appointed by the official designated under the provisions of the~~
9 ~~county's charter.))~~)

10 The local health officer shall be an experienced physician licensed
11 to practice medicine and surgery or osteopathy and surgery in this
12 state and who is qualified or provisionally qualified in accordance
13 with the standards prescribed in RCW 70.05.051 through 70.05.055 to
14 hold the office of local health officer. No term of office shall be
15 established for the local health officer but ((he)) the local health
16 officer shall not be removed until after notice is given ((him)), and
17 an opportunity for a hearing before the board or official responsible
18 for his or her appointment under this section as to the reason for his
19 or her removal. ((He)) The local health officer shall act as executive
20 secretary to, and administrative officer for the local board of health
21 and shall also be empowered to employ such technical and other
22 personnel as approved by the local board of health except where the
23 local board of health has appointed an administrative officer under RCW
24 70.05.040. The local health officer shall be paid such salary and
25 allowed such expenses as shall be determined by the local board of
26 health.

27 **Sec. 239.** RCW 70.05.070 and 1991 c 3 s 309 are each amended to
28 read as follows:

29 LOCAL HEALTH OFFICER DUTIES. The local health officer, acting
30 under the direction of the local board of health or under direction of
31 the administrative officer appointed under RCW 70.05.040 or section 237
32 of this act, if any, shall:

33 (1) Enforce the public health statutes of the state, rules of the
34 state board of health and the secretary of health, and all local health
35 rules, regulations and ordinances within his or her jurisdiction
36 including imposition of penalties authorized under RCW 70.119A.030 and
37 filing of actions authorized by RCW 43.70.190;

1 (2) Take such action as is necessary to maintain health and
2 sanitation supervision over the territory within his or her
3 jurisdiction;

4 (3) Control and prevent the spread of any dangerous, contagious or
5 infectious diseases that may occur within his or her jurisdiction;

6 (4) Inform the public as to the causes, nature, and prevention of
7 disease and disability and the preservation, promotion and improvement
8 of health within his or her jurisdiction;

9 (5) Prevent, control or abate nuisances which are detrimental to
10 the public health;

11 (6) Attend all conferences called by the secretary of health or his
12 or her authorized representative;

13 (7) Collect such fees as are established by the state board of
14 health or the local board of health for the issuance or renewal of
15 licenses or permits or such other fees as may be authorized by law or
16 by the rules of the state board of health;

17 (8) Inspect, as necessary, expansion or modification of existing
18 public water systems, and the construction of new public water systems,
19 to assure that the expansion, modification, or construction conforms to
20 system design and plans;

21 (9) Take such measures as he or she deems necessary in order to
22 promote the public health, to participate in the establishment of
23 health educational or training activities, and to authorize the
24 attendance of employees of the local health department or individuals
25 engaged in community health programs related to or part of the programs
26 of the local health department.

27 **Sec. 240.** RCW 70.05.080 and 1991 c 3 s 310 are each amended to
28 read as follows:

29 LOCAL HEALTH OFFICER--APPOINTMENT BY SECRETARY OF HEALTH IF LOCAL
30 BOARD FAILS TO ACT. If the local board of health or other official
31 responsible for appointing a local health officer under RCW 70.05.050
32 refuses or neglects to appoint a local health officer after a vacancy
33 exists, the secretary of health may appoint a local health officer and
34 fix the compensation. The local health officer so appointed shall have
35 the same duties, powers and authority as though appointed under RCW
36 70.05.050. Such local health officer shall serve until a qualified
37 individual is appointed according to the procedures set forth in RCW
38 70.05.050. The board or official responsible for appointing the local

1 health officer under RCW 70.05.050 shall also be authorized to appoint
2 an acting health officer to serve whenever the health officer is absent
3 or incapacitated and unable to fulfill his or her responsibilities
4 under the provisions of chapters 70.05 and 70.46 RCW (~~and RCW~~
5 ~~70.46.020 through 70.46.090~~)).

6 **Sec. 241.** RCW 70.05.120 and 1984 c 25 s 8 are each amended to read
7 as follows:

8 REMOVAL OF LOCAL HEALTH OFFICER. Any local health officer or
9 administrative officer appointed under RCW 70.05.040, if any, who shall
10 refuse or neglect to obey or enforce the provisions of chapters 70.05
11 and 70.46 RCW (~~and RCW 70.46.020 through 70.46.090~~) or the rules,
12 regulations or orders of the state board of health or who shall refuse
13 or neglect to make prompt and accurate reports to the state board of
14 health, may be removed as local health officer or administrative
15 officer by the state board of health and shall not again be reappointed
16 except with the consent of the state board of health. Any person may
17 complain to the state board of health concerning the failure of the
18 local health officer or administrative officer to carry out the laws or
19 the rules and regulations concerning public health, and the state board
20 of health shall, if a preliminary investigation so warrants, call a
21 hearing to determine whether the local health officer or administrative
22 officer is guilty of the alleged acts. Such hearings shall be held
23 pursuant to the provisions of chapter 34.05 RCW, and the rules and
24 regulations of the state board of health adopted thereunder.

25 Any member of a local board of health who shall violate any of the
26 provisions of chapters 70.05 and 70.46 RCW (~~and RCW 70.46.020 through~~
27 ~~70.46.090~~) or refuse or neglect to obey or enforce any of the rules,
28 regulations or orders of the state board of health made for the
29 prevention, suppression or control of any dangerous contagious or
30 infectious disease or for the protection of the health of the people of
31 this state, shall be guilty of a misdemeanor, and upon conviction shall
32 be fined not less than ten dollars nor more than two hundred dollars.
33 Any physician who shall refuse or neglect to report to the proper
34 health officer or administrative officer within twelve hours after
35 first attending any case of contagious or infectious disease or any
36 diseases required by the state board of health to be reported or any
37 case suspicious of being one of such diseases, shall be guilty of a
38 misdemeanor, and upon conviction shall be fined not less than ten

1 dollars nor more than two hundred dollars for each case that is not
2 reported.

3 Any person violating any of the provisions of chapters 70.05 and
4 70.46 RCW (~~and RCW 70.46.020 through 70.46.090~~) or violating or
5 refusing or neglecting to obey any of the rules, regulations or orders
6 made for the prevention, suppression and control of dangerous
7 contagious and infectious diseases by the local board of health or
8 local health officer or administrative officer or state board of
9 health, or who shall leave any isolation hospital or quarantined house
10 or place without the consent of the proper health officer or who evades
11 or breaks quarantine or conceals a case of contagious or infectious
12 disease or assists in evading or breaking any quarantine or concealing
13 any case of contagious or infectious disease, shall be guilty of a
14 misdemeanor, and upon conviction thereof shall be subject to a fine of
15 not less than twenty-five dollars nor more than one hundred dollars or
16 to imprisonment in the county jail not to exceed ninety days or to both
17 fine and imprisonment.

18 **Sec. 242.** RCW 70.05.130 and 1991 c 3 s 313 are each amended to
19 read as follows:

20 EXPENSES OF CARRYING OUT PUBLIC HEALTH LAW. All expenses incurred
21 by the state, health district, or county in carrying out the provisions
22 of chapters 70.05 and 70.46 RCW (~~and RCW 70.46.020 through 70.46.090~~)
23 or any other public health law, or the rules of the (~~state~~)
24 department of health enacted under such laws, shall be paid by the
25 county (~~or city by which or in behalf of which such expenses shall~~
26 ~~have been incurred~~) and such expenses shall constitute a claim against
27 the general fund as provided (~~herein~~) in this section.

28 **Sec. 243.** RCW 70.05.150 and 1967 ex.s. c 51 s 22 are each amended
29 to read as follows:

30 AUTHORITY TO CONTRACT. In addition to powers already granted them,
31 any (~~city, town,~~) county, district, or local health department may
32 contract for either the sale or purchase of any or all health services
33 from any local health department(~~PROVIDED, That~~). Such contract
34 shall require the approval of the state board of health.

35 **Sec. 244.** RCW 70.08.010 and 1985 c 124 s 1 are each amended to
36 read as follows:

1 APPOINTMENT OF LOCAL HEALTH OFFICER BY COMBINED CITY AND COUNTY
2 HEALTH DEPARTMENT. Any city with one hundred thousand or more
3 population and the county in which it is located, are authorized, as
4 shall be agreed upon between the respective governing bodies of such
5 city and said county, to establish and operate a combined city and
6 county health department, and to appoint ~~((the director of public
7 health))~~ a local health officer for the county served. Class AA
8 counties may appoint a director of public health as specified in this
9 chapter.

10 **Sec. 245.** RCW 70.12.030 and 1945 c 46 s 1 are each amended to read
11 as follows:

12 MONEY MANAGEMENT. Any county, ~~((first class city))~~ combined city-
13 county health department, or health district is hereby authorized and
14 empowered to create a "public health pooling fund", hereafter called
15 the "fund", for the efficient management and control of all moneys
16 coming to such county, ~~((first class city))~~ combined department, or
17 district for public health purposes.

18 ~~(("Health district" as used herein may mean all territory
19 consisting of one or more counties and all cities with a population of
20 one hundred thousand or less, and towns therein.))~~

21 **Sec. 246.** RCW 70.12.050 and 1945 c 46 s 3 are each amended to read
22 as follows:

23 EXPENDITURES. All expenditures in connection with salaries, wages
24 and operations incurred in carrying on the health department of the
25 county, ~~((first class city))~~ combined city-county health department, or
26 health district shall be paid out of such fund.

27 **Sec. 247.** RCW 70.46.020 and 1967 ex.s. c 51 s 6 are each amended
28 to read as follows:

29 MULTICOUNTY HEALTH DISTRICTS. Health districts consisting of two
30 or more counties may be created whenever two or more boards of county
31 commissioners shall by resolution establish a district for such
32 purpose. Such a district shall consist of all the area of the combined
33 counties ~~((including all cities and towns except cities of over one
34 hundred thousand population)).~~ The district board of health of such a
35 district shall consist of not less than five members for districts of
36 two counties and seven members for districts of more than two counties,

1 including two representatives from each county who are members of the
2 board of county commissioners and who are appointed by the board of
3 county commissioners of each county within the district, and shall have
4 a jurisdiction coextensive with the combined boundaries. ((The
5 remaining members shall be representatives of the cities and towns in
6 the district selected by mutual agreement of the legislative bodies of
7 the cities and towns concerned from their membership, taking into
8 consideration the financial contribution of such cities and towns and
9 representation from the several classifications of cities and towns.))

10 At the first meeting of a district board of health the members
11 shall elect a ((~~chairman~~)) chair to serve for a period of one year.

12 **Sec. 248.** RCW 70.46.060 and 1967 ex.s. c 51 s 11 are each amended
13 to read as follows:

14 DISTRICT BOARD OF HEALTH POWERS AND DUTIES. The district board of
15 health shall constitute the local board of health for all the territory
16 included in the health district, and shall supersede and exercise all
17 the powers and perform all the duties by law vested in the county ((~~or~~
18 ~~city or town~~)) board of health of any county((~~, city or town~~)) included
19 in the health district((~~, except as otherwise in chapter 70.05 RCW and~~
20 ~~RCW 70.46.020 through 70.46.090 provided~~)).

21 **Sec. 249.** RCW 70.46.080 and 1971 ex.s. c 85 s 10 are each amended
22 to read as follows:

23 DISTRICT HEALTH FUND. Each health district shall establish a fund
24 to be designated as the "district health fund", in which shall be
25 placed all sums received by the district from any source, and out of
26 which shall be expended all sums disbursed by the district. ((The
27 ~~county treasurer of the county in the district embracing only one~~
28 ~~county; or,~~)) In a district composed of more than one county the county
29 treasurer of the county having the largest population shall be the
30 custodian of the fund, and the county auditor of said county shall keep
31 the record of the receipts and disbursements, and shall draw and the
32 county treasurer shall honor and pay all warrants, which shall be
33 approved before issuance and payment as directed by the board((~~;~~
34 PROVIDED, That in local health departments wherein a city of over one
35 hundred thousand population is a part of said department, the local
36 board of health may pool the funds available for public health purposes

1 in the office of the city treasurer in a special pooling fund to be
2 established and which shall be expended as set forth above)).

3 Each county(~~(, city or town)~~) which is included in the district
4 shall contribute such sums towards the expense for maintaining and
5 operating the district as shall be agreed upon between it and the local
6 board of health in accordance with guidelines established by the state
7 board of health (~~(after consultation with the Washington state~~
8 ~~association of counties and the association of Washington cities. In~~
9 ~~the event that no agreement can be reached between the district board~~
10 ~~of health and the county, city or town, the matter shall be resolved by~~
11 ~~a board of arbitrators to consist of a representative of the district~~
12 ~~board of health, a representative from the county, city or town~~
13 ~~involved, and a third representative to be appointed by the two~~
14 ~~representatives, but if they are unable to agree, a representative~~
15 ~~shall be appointed by a judge in the county in which the city or town~~
16 ~~is located. The determination of the proportionate share to be paid by~~
17 ~~a county, city or town shall be binding on all parties. Payments into~~
18 ~~the fund of the district may be made by the county or city or town~~
19 ~~members during the first year of membership in said district from any~~
20 ~~funds of the respective county, city or town as would otherwise be~~
21 ~~available for expenditures for health facilities and services, and~~
22 ~~thereafter the members shall include items in their respective budgets~~
23 ~~for payments to finance the health district)).~~

24 **Sec. 250.** RCW 70.46.085 and 1967 ex.s. c 51 s 20 are each amended
25 to read as follows:

26 COUNTY TO BEAR EXPENSES. The expense of providing public health
27 services shall be borne by each county(~~(, city or town)~~) within the
28 health district(~~(, and the local health officer shall certify the~~
29 ~~amount agreed upon or as determined pursuant to RCW 70.46.080, and~~
30 ~~remaining unpaid by each county, city or town to the fiscal or warrant~~
31 ~~issuing officer of such county, city or town.~~

32 If the expense as certified is not paid by any county, city or town
33 within thirty days after the end of the fiscal year, the local health
34 officer shall certify the amount due to the auditor of the county in
35 which the governmental unit is situated who shall promptly issue his
36 warrant on the county treasurer payable out of the current expense fund
37 of the county, which fund shall be reimbursed by the county auditor out
38 of the money due said governmental unit at the next monthly settlement

1 ~~or settlements of the collection of taxes and shall be transferred to~~
2 ~~the current expense fund)).~~

3 **Sec. 251.** RCW 70.46.090 and 1967 ex.s. c 51 s 21 are each amended
4 to read as follows:

5 WITHDRAWAL FROM MEMBERSHIP. Any county (~~or any city or town~~) may
6 withdraw from membership in said health district any time after it has
7 been within the district for a period of two years, but no withdrawal
8 shall be effective except at the end of the calendar year in which the
9 county(~~, city or town~~) gives at least six months' notice of its
10 intention to withdraw at the end of the calendar year. No withdrawal
11 shall entitle any member to a refund of any moneys paid to the district
12 nor relieve it of any obligations to pay to the district all sums for
13 which it obligated itself due and owing by it to the district for the
14 year at the end of which the withdrawal is to be effective(~~+~~
15 ~~PROVIDED, That~~)). Any county(~~, city or town~~) which withdraws from
16 membership in said health district shall immediately establish a health
17 department or provide health services which shall meet the standards
18 for health services promulgated by the state board of health(~~+~~
19 PROVIDED FURTHER, That)). No local health department (~~shall~~) may be
20 deemed to provide adequate public health services unless there is at
21 least one full time professionally trained and qualified physician as
22 set forth in RCW 70.05.050.

23 **Sec. 252.** RCW 70.46.120 and 1963 c 121 s 1 are each amended to
24 read as follows:

25 FEES MAY BE CHARGED. In addition to all other powers and duties,
26 health districts shall have the power to charge fees in connection with
27 the issuance or renewal of a license or permit required by law:
28 PROVIDED, That the fees charged shall not exceed the actual cost
29 involved in issuing or renewing the license or permit(~~+~~ ~~PROVIDED~~
30 ~~FURTHER, That no fees shall be charged pursuant to this section within~~
31 ~~the corporate limits of any city or town which prior to the enactment~~
32 ~~of this section charged fees in connection with the issuance or renewal~~
33 ~~of a license or permit pursuant to city or town ordinance and where~~
34 ~~said city or town makes a direct contribution to said health district,~~
35 ~~unless such city or town expressly consents thereto)).~~

1 **Sec. 253.** RCW 82.44.110 and 1991 c 199 s 221 are each amended to
2 read as follows:

3 DISPOSITION OF MOTOR VEHICLE EXCISE TAX REVENUE--PUBLIC HEALTH.
4 The county auditor shall regularly, when remitting license fee
5 receipts, pay over and account to the director of licensing for the
6 excise taxes collected under the provisions of this chapter. The
7 director shall forthwith transmit the excise taxes to the state
8 treasurer.

9 (1) The state treasurer shall deposit the excise taxes collected
10 under RCW 82.44.020(1) as follows:

11 (a) 1.60 percent into the motor vehicle fund to defray
12 administrative and other expenses incurred by the department in the
13 collection of the excise tax.

14 (b) 8.15 percent into the Puget Sound capital construction account
15 in the motor vehicle fund.

16 (c) 4.07 percent into the Puget Sound ferry operations account in
17 the motor vehicle fund.

18 (d) (~~(8.83)~~) 5.88 percent into the general fund to be distributed
19 under RCW 82.44.155.

20 (e) 4.75 percent into the municipal sales and use tax equalization
21 account in the general fund created in RCW 82.14.210.

22 (f) 1.60 percent into the county sales and use tax equalization
23 account in the general fund created in RCW 82.14.200.

24 (g) 62.6440 percent into the general fund through June 30, 1993,
25 57.6440 percent into the general fund beginning July 1, 1993, and 66
26 percent into the general fund beginning January 1, 1994.

27 (h) 5 percent into the transportation fund created in RCW 82.44.180
28 beginning July 1, 1993.

29 (i) 5.9686 percent into the county criminal justice assistance
30 account created in RCW 82.14.310 through December 31, 1993.

31 (j) 1.1937 percent into the municipal criminal justice assistance
32 account for distribution under RCW 82.14.320 through December 31, 1993.

33 (k) 1.1937 percent into the municipal criminal justice assistance
34 account for distribution under RCW 82.14.330 through December 31, 1993.

35 (l) 2.95 percent into the general fund to be distributed by the
36 state treasurer to county health departments to be used exclusively for
37 public health. The state treasurer shall distribute these funds
38 proportionately among the counties based on population as determined by
39 the most recent United States census.

1 (2) The state treasurer shall deposit the excise taxes collected
2 under RCW 82.44.020(2) into the transportation fund.

3 (3) The state treasurer shall deposit the excise tax imposed by RCW
4 82.44.020(3) into the air pollution control account created by RCW
5 70.94.015.

6 **Sec. 254.** RCW 82.44.155 and 1991 c 199 s 223 are each amended to
7 read as follows:

8 MOTOR VEHICLE EXCISE TAX DISTRIBUTION TO CITIES AND TOWNS. When
9 distributions are made under RCW 82.44.150, the state treasurer shall
10 apportion and distribute the motor vehicle excise taxes deposited into
11 the general fund under RCW 82.44.110(~~((+4))~~)(1)(d) to the cities and
12 towns ratably on the basis of population as last determined by the
13 office of financial management. When so apportioned, the amount
14 payable to each such city and town shall be transmitted to the city
15 treasurer thereof, and shall be used by the city or town for the
16 purposes of police and fire protection (~~((and the preservation of the
17 public health))~~) in the city or town, and not otherwise. If it is
18 adjudged that revenue derived from the excise taxes imposed by RCW
19 82.44.020 (1) and (2) cannot lawfully be apportioned or distributed to
20 cities or towns, all moneys directed by this section to be apportioned
21 and distributed to cities and towns shall be credited and transferred
22 to the state general fund.

23 **Sec. 255.** RCW 43.20.030 and 1984 c 287 s 75 are each amended to
24 read as follows:

25 COMPOSITION OF STATE BOARD OF HEALTH--CITY MEMBER ELIMINATED. The
26 state board of health shall be composed of ten members. These shall be
27 the secretary or the secretary's designee and nine other persons to be
28 appointed by the governor, including four persons experienced in
29 matters of health and sanitation, (~~((an elected city official who is a
30 member of a local health board, an))~~) two elected county officials who
31 (~~((is a))~~) are members of a local health board, a local health officer,
32 and two persons representing the consumers of health care. (~~((Before
33 appointing the city official, the governor shall consider any
34 recommendations submitted by the association of Washington cities.))~~)
35 Before appointing the county official, the governor shall consider any
36 recommendations submitted by the Washington state association of
37 counties. Before appointing the local health officer, the governor

1 shall consider any recommendations submitted by the Washington state
2 association of local public health officials. Before appointing one of
3 the two consumer representatives, the governor shall consider any
4 recommendations submitted by the state council on aging. The chairman
5 shall be selected by the governor from among the nine appointed
6 members. The department (~~of social and health services~~) shall
7 provide necessary technical staff support to the board. The board may
8 employ an executive director and a confidential secretary, each of whom
9 shall be exempt from the provisions of the state civil service law,
10 chapter 41.06 RCW.

11 Members of the board shall be compensated in accordance with RCW
12 43.03.240 and shall be reimbursed for their travel expenses in
13 accordance with RCW 43.03.050 and 43.03.060.

14 NEW SECTION. **Sec. 256.** RECODIFICATION--CITY/COUNTY HEALTH
15 DEPARTMENT. RCW 70.08.010, as amended by this act, shall be recodified
16 in chapter 70.05 RCW.

17 NEW SECTION. **Sec. 257.** REPEALERS--CITIES AND TOWNS. The
18 following acts or parts of acts are each repealed:

- 19 (1) RCW 70.05.005 and 1989 1st ex.s. c 9 s 243;
- 20 (2) RCW 70.05.020 and 1967 ex.s. c 51 s 2;
- 21 (3) RCW 70.05.132 and 1984 c 25 s 9 & 1983 1st ex.s. c 39 s 6;
- 22 (4) RCW 70.05.145 and 1983 1st ex.s. c 39 s 5;
- 23 (5) RCW 70.12.005 and 1989 1st ex.s. c 9 s 245;
- 24 (6) RCW 70.46.030 and 1991 c 363 s 141, 1969 ex.s. c 70 s 1, 1967
25 ex.s. c 51 s 5, & 1945 c 183 s 3;
- 26 (7) RCW 70.46.040 and 1967 ex.s. c 51 s 7 & 1945 c 183 s 4; and
- 27 (8) RCW 70.46.050 and 1967 ex.s. c 51 s 8, 1957 c 100 s 1, & 1945
28 c 183 s 5.

29 NEW SECTION. **Sec. 258.** STUDY LOCAL GOVERNMENT HEALTH SERVICE
30 DELIVERY. It is hereby requested that the governing authorities of the
31 association of Washington cities, the Washington state association of
32 counties, and the Washington association of county officials jointly
33 initiate a study and develop consensus recommendations regarding
34 implementation of the provisions of sections 234 through 257 of this
35 act. The study and recommendations should at a minimum include
36 consideration of the fiscal impact of these sections on counties, the

1 desirability of maintaining a process whereby city officials can
2 effectively communicate concerns regarding the delivery of public
3 health services to both the counties and the state, the need for larger
4 cities to be able to continue to provide health care services when
5 needed, and other matters as the three associations agree are of
6 substance in the implementation of sections 234 through 257 of this
7 act. This study shall be coordinated with the public health services
8 improvement planning process set forth in section 467 of this act. The
9 agreed upon recommendations shall be presented to the senate health and
10 human services and house of representatives health care committees
11 prior to March 1, 1994.

12

F. DATA COLLECTION

13 **Sec. 259.** RCW 70.170.100 and 1990 c 269 s 12 are each amended to
14 read as follows:

15 STATE-WIDE DATA SYSTEM--HEALTH SERVICES COMMISSION. (1) To promote
16 the public interest consistent with the purposes of chapter . . . , Laws
17 of 1993 (this act), the department is responsible for the development,
18 implementation, and custody of a state-wide ((hospital)) health care
19 data system, with policy direction and oversight to be provided by the
20 Washington health services commission. As part of the design stage for
21 development of the system, the department shall undertake a needs
22 assessment of the types of, and format for, ((hospital)) health care
23 data needed by consumers, purchasers, health care payers, ((hospitals))
24 providers, and state government as consistent with the intent of
25 chapter . . . , Laws of 1993 (this act) ((chapter)). The department
26 shall identify a set of ((hospital)) health care data elements and
27 report specifications which satisfy these needs. The ((council))
28 Washington health services commission, created by section 403 of this
29 act, shall review the design of the data system and may ((direct the
30 department to)) establish a technical advisory committee on health data
31 and may, if deemed cost-effective and efficient, recommend that the
32 department contract with a private vendor for assistance in the design
33 of the data system or for any part of the work to be performed under
34 this section. The data elements, specifications, and other ((design))
35 distinguishing features of this data system shall be made available for
36 public review and comment and shall be published, with comments, as the
37 department's first data plan by ((January 1, 1990)) July 1, 1994.

1 (2) Subsequent to the initial development of the data system as
2 published as the department's first data plan, revisions to the data
3 system shall be considered (~~((through the department's development of a~~
4 ~~biennial data plan, as proposed to,~~) with the oversight and policy
5 guidance of the Washington health services commission or its technical
6 advisory committee and funded by(~~(7)~~) the legislature through the
7 biennial appropriations process with funds appropriated to the health
8 services account. (~~(Costs of data activities outside of these data~~
9 ~~plans except for special studies shall be funded through legislative~~
10 ~~appropriations.~~

11 (3)) In designing the state-wide (~~(hospital)~~) health care data
12 system and any data plans, the department shall identify ((hospital))
13 health care data elements relating to ((both hospital finances)) health
14 care costs, the quality of health care services, the outcomes of health
15 care services, and ((the)) use of ((services by patients)) health care
16 by consumers. Data elements (~~(relating to hospital finances))~~ shall be
17 reported (~~(by hospitals))~~ as the Washington health services commission
18 directs by reporters in conformance with a uniform (~~(system of))~~
19 reporting (~~(as specified by the department and shall))~~ system
20 established by the department, which shall be adopted by reporters.
21 "Reporter" means an individual, hospital, or business entity, required
22 to be registered with the department of revenue for payment of taxes
23 imposed under chapter 82.04 RCW or Title 48 RCW, that is primarily
24 engaged in furnishing or insuring for medical, surgical, and other
25 health services to persons. In the case of hospitals this includes
26 data elements identifying each hospital's revenues, expenses,
27 contractual allowances, charity care, bad debt, other income, total
28 units of inpatient and outpatient services, and other financial
29 information reasonably necessary to fulfill the purposes of chapter
30 . . ., Laws of 1993 (this ((chapter)) act), for hospital activities as
31 a whole and, as feasible and appropriate, for specified classes of
32 hospital purchasers and payers. Data elements relating to use of
33 hospital services by patients shall, at least initially, be the same as
34 those currently compiled by hospitals through inpatient discharge
35 abstracts ((and reported to the Washington state hospital commission)).
36 The commission and the department shall encourage and permit reporting
37 by electronic transmission or hard copy as is practical and economical
38 to reporters.

1 ~~((4))~~ (3) The state-wide ~~((hospital))~~ health care data system
2 shall be uniform in its identification of reporting requirements for
3 ~~((hospitals))~~ reporters across the state to the extent that such
4 uniformity is ~~((necessary))~~ useful to fulfill the purposes of chapter
5 . . . , Laws of 1993 (this ((chapter)) act). Data reporting
6 requirements may reflect differences ~~((in hospital size; urban or rural~~
7 ~~location; scope, type, and method of providing service; financial~~
8 ~~structure; or other pertinent distinguishing factors))~~ that involve
9 pertinent distinguishing features as determined by the Washington
10 health services commission by rule. So far as ~~((possible))~~ is
11 practical, the data system shall be coordinated with any requirements
12 of the trauma care data registry as authorized in RCW 70.168.090, the
13 federal department of health and human services in its administration
14 of the medicare program, ~~((and))~~ the state in its role of gathering
15 public health statistics, or any other payer program of consequence so
16 as to minimize any unduly burdensome reporting requirements imposed on
17 ~~((hospitals))~~ reporters.

18 ~~((5))~~ (4) In identifying financial reporting requirements under
19 the state-wide ~~((hospital))~~ health care data system, the department may
20 require both annual reports and condensed quarterly reports from
21 reporters, so as to achieve both accuracy and timeliness in reporting,
22 but shall craft such requirements with due regard of the data reporting
23 burdens of reporters.

24 ~~((6))~~ In designing the initial state-wide hospital data system as
25 published in the department's first data plan, the department shall
26 review all existing systems of hospital financial and utilization
27 reporting used in this state to determine their usefulness for the
28 purposes of this chapter, including their potential usefulness as
29 revised or simplified.

30 (7) ~~Until such time as the state wide hospital data system and~~
31 ~~first data plan are developed and implemented and hospitals are able to~~
32 ~~comply with reporting requirements, the department shall require~~
33 ~~hospitals to continue to submit the hospital financial and patient~~
34 ~~discharge information previously required to be submitted to the~~
35 ~~Washington state hospital commission. Upon publication of the first~~
36 ~~data plan, hospitals shall have a reasonable period of time to comply~~
37 ~~with any new reporting requirements and, even in the event that new~~
38 ~~reporting requirements differ greatly from past requirements, shall~~
39 ~~comply within two years of July 1, 1989.~~

1 ~~(8))~~ (5) The ~~((hospital))~~ health care data collected ((and)),
2 maintained, and studied by the department or the Washington health
3 services commission shall only be available for retrieval in original
4 or processed form to public and private requestors and shall be
5 available within a reasonable period of time after the date of request.
6 The cost of retrieving data for state officials and agencies shall be
7 funded through the state general appropriation. The cost of retrieving
8 data for individuals and organizations engaged in research or private
9 use of data or studies shall be funded by a fee schedule developed by
10 the department which reflects the direct cost of retrieving the data or
11 study in the requested form.

12 (6) All persons subject to chapter . . . , Laws of 1993 (this act)
13 shall comply with departmental or commission requirements established
14 by rule in the acquisition of data.

15 **Sec. 260.** RCW 70.170.110 and 1989 1st ex.s. c 9 s 511 are each
16 amended to read as follows:

17 HEALTH CARE DATA--STUDIES, ANALYSES, OR REPORTS. The department
18 shall provide, or may contract with a private entity to provide,
19 ~~((hospital))~~ analyses and reports or any studies it chooses to conduct
20 consistent with the purposes of chapter . . . , Laws of 1993 (this
21 ~~((chapter))~~ act), subject to the availability of funds and any policy
22 direction that may be given by the Washington health services
23 commission. ((Prior to release, the department shall provide affected
24 hospitals with an opportunity to review and comment on reports which
25 identify individual hospital data with respect to accuracy and
26 completeness, and otherwise shall focus on aggregate reports of
27 hospital performance.)) These studies, analyses, or reports shall
28 include:

29 (1) Consumer guides on purchasing ((hospital care services and)) or
30 consuming health care and publications providing verifiable and useful
31 aggregate comparative information to ((consumers on hospitals and
32 hospital services)) the public on health care services, their cost, and
33 the quality of health care providers who participate in certified
34 health plans;

35 (2) Reports for use by classes of purchasers, who purchase from
36 certified health plans, health care payers, and providers as specified
37 for content and format in the state-wide data system and data plan;
38 ~~((and))~~

1 (3) Reports on relevant (~~hospital~~) health care policy (~~issues~~)
2 including the distribution of hospital charity care obligations among
3 hospitals; absolute and relative rankings of Washington and other
4 states, regions, and the nation with respect to expenses, net revenues,
5 and other key indicators; (~~hospital~~) provider efficiencies; and the
6 effect of medicare, medicaid, and other public health care programs on
7 rates paid by other purchasers of (~~hospital~~) health care; and
8 (4) Any other reports the commission or department deems useful to
9 assist the public or purchasers of certified health plans in
10 understanding the prudent and cost-effective use of certified health
11 plan services.

12 NEW SECTION. Sec. 261. A new section is added to chapter 70.170
13 RCW to read as follows:

14 CONFIDENTIALITY OF DATA. (1) Notwithstanding the provisions of
15 chapter 42.17 RCW, any material contained within the state-wide health
16 care data system or in the files of either the department or the
17 Washington health services commission shall be subject to the following
18 limitations: (a) Records obtained, reviewed by, or on file that
19 contain information concerning medical treatment of individuals shall
20 be exempt from public inspection and copying; and (b) any actuarial
21 formulas, statistics, and assumptions submitted by a certified health
22 plan to the commission or department upon request shall be exempt from
23 public inspection and copying in order to preserve trade secrets or
24 prevent unfair competition.

25 (2) All persons and any public or private agencies or entities
26 whatsoever subject to this chapter shall comply with any requirements
27 established by rule relating to the acquisition or use of health
28 services data and maintain the confidentiality of any information that
29 may, in any manner, identify individual persons.

30 (3) Data collected pursuant to sections 262 and 263 of this act
31 shall be used solely for the health care reform provisions of chapter
32 ..., Laws of 1993 (this act). The department shall ensure that the
33 enrollee identifier used will employ the highest available standards
34 for accuracy and uniqueness.

35 (4) Nothing in this section shall impede an enrollee's access to
36 her or his health care records as provided in chapter 70.02 RCW.

1 NEW SECTION. **Sec. 262.** A new section is added to chapter 70.170
2 RCW to read as follows:

3 HEALTH SERVICES COMMISSION ACCESS TO DATA. The Washington health
4 services commission shall have access to all health data available to
5 the secretary of health. To the extent possible, the commission shall
6 use existing data systems and coordinate among existing agencies. The
7 department of health shall be the designated depository agency for all
8 health data collected pursuant to chapter . . . , Laws of 1993 (this
9 act). The following data sources shall be developed or made available:

10 (1) The commission shall coordinate with the secretary of health to
11 utilize data collected by the state center for health statistics,
12 including hospital charity care and related data, rural health data,
13 epidemiological data, ethnicity data, social and economic status data,
14 and other data relevant to the commission's responsibilities.

15 (2) The commission, in coordination with the department of health
16 and the health science programs of the state universities shall develop
17 procedures to analyze clinical and other health services outcome data,
18 and conduct other research necessary for the specific purpose of
19 assisting in the design of the uniform benefits package under chapter
20 . . . , Laws of 1993 (this act).

21 (3) The commission shall establish cost data sources and shall
22 require each certified health plan to provide the commission and the
23 department of health with enrollee care and cost information, to
24 include, but not be limited to: (a) Enrollee identifier, including
25 date of birth, sex, and ethnicity; (b) provider identifier; (c)
26 diagnosis; (d) health care services or procedures provided; (e)
27 provider charges, if any; and (f) amount paid. The department shall
28 establish by rule confidentiality standards to safeguard the
29 information from inappropriate use or release.

30 (4) The commission shall coordinate with the area Indian health
31 service, reservation Indian health service units, tribal clinics, and
32 any urban Indian health service organizations the design, development,
33 implementation, and maintenance of an American Indian-specific health
34 data, statistics information system. The commission rules regarding
35 the confidentiality to safeguard the information from inappropriate use
36 or release shall apply.

37 NEW SECTION. **Sec. 263.** A new section is added to chapter 70.170
38 RCW to read as follows:

1 PERSONAL HEALTH SERVICES DATA AND INFORMATION SYSTEM. (1) The
2 department is responsible for the implementation and custody of a
3 state-wide personal health services data and information system. The
4 data elements, specifications, and other design features of this data
5 system shall be consistent with criteria adopted by the Washington
6 health services commission. The department shall provide the
7 commission with reasonable assistance in the development of these
8 criteria, and shall provide the commission with periodic progress
9 reports related to the implementation of the system or systems related
10 to those criteria.

11 (2) The department shall coordinate the development and
12 implementation of the personal health services data and information
13 system with related private activities and with the implementation
14 activities of the data sources identified by the commission. Data
15 shall include: (a) Enrollee identifier, including date of birth, sex,
16 and ethnicity; (b) provider identifier; (c) diagnosis; (d) health
17 services or procedures provided; (e) provider charges, if any; and (f)
18 amount paid. The commission shall establish by rule, confidentiality
19 standards to safeguard the information from inappropriate use or
20 release. The department shall assist the commission in establishing
21 reasonable time frames for the completion of the system development and
22 system implementation.

23 NEW SECTION. **Sec. 264.** HEALTH CARE ENTITY REPORTING REQUIREMENTS.
24 The commission shall determine, by January 1, 1995, the necessity, if
25 any, of reporting requirements by the following health care entities:
26 Health care providers, health care facilities, insuring entities, and
27 certified health plans. The reporting requirements, if any, shall be
28 for the purposes of determining whether the health care system is
29 operating as efficiently as possible. Information reported pursuant to
30 this section shall be made available to interested parties upon
31 request. The commission shall report its findings to the legislature
32 by January 1, 1995.

33 **G. DISCLOSURE OF HOSPITAL, NURSING HOME, AND PHARMACY CHARGES**

34 NEW SECTION. **Sec. 265.** A new section is added to chapter 70.41
35 RCW to read as follows:

1 SPIRALING COSTS--HOSPITALS. (1) The legislature finds that the
2 spiraling costs of health care continue to surmount efforts to contain
3 them, increasing at approximately twice the inflationary rate. The
4 causes of this phenomenon are complex. By making physicians and other
5 health care providers with hospital admitting privileges more aware of
6 the cost consequences of health care services for consumers, these
7 providers may be inclined to exercise more restraint in providing only
8 the most relevant and cost-beneficial hospital services, with a
9 potential for reducing the utilization of those services. The
10 requirement of the hospital to inform physicians and other health care
11 providers of the charges of the health care services that they order
12 may have a positive effect on containing health costs. Further, the
13 option of the physician or other health care provider to inform the
14 patient of these charges may strengthen the necessary dialogue in the
15 provider-patient relationship that tends to be diminished by
16 intervening third-party payers.

17 (2) The chief executive officer of a hospital licensed under this
18 chapter and the superintendent of a state hospital shall establish and
19 maintain a procedure for disclosing to physicians and other health care
20 providers with admitting privileges the charges of all health care
21 services ordered for their patients. Copies of hospital charges shall
22 be made available to any physician and/or other health care provider
23 ordering care in hospital inpatient/outpatient services. The physician
24 and/or other health care provider may inform the patient of these
25 charges and may specifically review them. Hospitals are also directed
26 to study methods for making daily charges available to prescribing
27 physicians through the use of interactive software and/or computerized
28 information thereby allowing physicians and other health care providers
29 to review not only the costs of present and past services but also
30 future contemplated costs for additional diagnostic studies and
31 therapeutic medications.

32 NEW SECTION. **Sec. 266.** A new section is added to chapter 18.68
33 RCW to read as follows:

34 SPIRALING COSTS--PRESCRIPTION MEDICATIONS. The legislature finds
35 that the spiraling costs of health care continue to surmount efforts to
36 contain them, increasing at approximately twice the inflationary rate.
37 One of the fastest growing segments of the health care expenditure
38 involves prescription medications. By making physicians and other

1 health care providers with prescriptive authority more aware of the
2 cost consequences of health care treatments for consumers, these
3 providers may be inclined to exercise more restraint in providing only
4 the most relevant and cost-beneficial drug and medication treatments.
5 The requirement of the pharmacy to inform physicians and other health
6 care providers of the charges of prescription drugs and medications
7 that they order may have a positive effect on containing health costs.
8 Further, the option of the physician or other health care provider to
9 inform the patient of these charges may strengthen the necessary
10 dialogue in the provider-patient relationship that tends to be
11 diminished by intervening third-party payers.

12 NEW SECTION. **Sec. 267.** A new section is added to chapter 18.68
13 RCW to read as follows:

14 COST OF PRESCRIPTIVE MEDICATIONS. The registered or licensed
15 pharmacist of this chapter shall establish and maintain a procedure for
16 disclosing to physicians and other health care providers with
17 prescriptive authority information detailed by prescriber, of the cost
18 and dispensation of all prescriptive medications prescribed by him or
19 her for his or her patients on request. These charges should be made
20 available on at least a quarterly basis for all requested patients and
21 should include medication, dosage, number dispensed, and the cost of
22 the prescription. Pharmacies may provide this information in a summary
23 form for each prescribing physician for all patients rather than as
24 individually itemized reports. All efforts should be made to utilize
25 the existing computerized records and software to provide this
26 information in the least costly format.

27 NEW SECTION. **Sec. 268.** A new section is added to chapter 18.51
28 RCW to read as follows:

29 SPIRALING COSTS--NURSING HOMES. (1) The legislature finds that the
30 spiraling costs of nursing home care continue to surmount efforts to
31 contain them, increasing at approximately twice the inflationary rate.
32 The causes of this phenomenon are complex. By making nursing home
33 facilities and care providers more aware of the cost consequences of
34 care services for consumers, these providers may be inclined to
35 exercise more restraint in providing only the most relevant and cost-
36 beneficial services and care, with a potential for reducing the
37 utilization of those services. The requirement of the nursing home to

1 inform physicians, consumers, and other care providers of the charges
2 of the services that they order may have a positive effect on
3 containing health costs.

4 (2) All nursing home administrators in facilities licensed under
5 this chapter shall be required to develop and maintain a written
6 procedure for disclosing patient charges to attending physicians with
7 admitting privileges. The nursing home administrator shall have the
8 capability to provide an itemized list of the charges for all health
9 care services that may be ordered by a physician. The information
10 shall be made available on request of consumers, or the physicians or
11 other appropriate health care providers responsible for prescribing
12 care.

13 **H. HEALTH PROFESSIONAL SHORTAGES**

14 NEW SECTION. **Sec. 269.** LEGISLATIVE INTENT. The legislature finds
15 that the successful implementation of health care reform will depend on
16 a sufficient supply of primary health care providers throughout the
17 state. Many rural and medically underserved urban areas lack primary
18 health care providers and because of this, basic health care services
19 are limited or unavailable to populations living in these areas. The
20 legislature has in recent years initiated new programs to address these
21 provider shortages but funding has been insufficient and additional
22 specific provider shortages remain.

23 **Sec. 270.** RCW 28B.125.010 and 1991 c 332 s 5 are each amended to
24 read as follows:

25 STATE-WIDE HEALTH PERSONNEL RESOURCE PLAN--PERSONS OF COLOR--INDIAN
26 HEALTH. (1) The higher education coordinating board, the state board
27 for community ((college—education)) and technical colleges, the
28 superintendent of public instruction, the state department of health,
29 the Washington health services commission, and the state department of
30 social and health services, to be known for the purposes of this
31 section as the committee, shall establish a state-wide health personnel
32 resource plan. The governor shall appoint a lead agency from one of
33 the agencies on the committee.

34 In preparing the state-wide plan the committee shall consult with
35 the training and education institutions affected by this chapter,

1 health care providers, employers of health care providers, insurers,
2 consumers of health care, and other appropriate entities.

3 Should a successor agency or agencies be authorized or created by
4 the legislature with planning, coordination, or administrative
5 authority over vocational-technical schools, community colleges, or
6 four-year higher education institutions, the governor shall grant
7 membership on the committee to such agency or agencies and remove the
8 member or members it replaces.

9 The committee shall appoint subcommittees for the purpose of
10 assisting in the development of the institutional plans required under
11 this chapter. Such subcommittees shall at least include those
12 committee members that have statutory responsibility for planning,
13 coordination, or administration of the training and education
14 institutions for which the institutional plans are being developed. In
15 preparing the institutional plans for four-year institutes of higher
16 education, the subcommittee shall be composed of at least the higher
17 education coordinating board and the state's four-year higher education
18 institutions. The appointment of subcommittees to develop portions of
19 the state-wide plan shall not relinquish the committee's responsibility
20 for assuring overall coordination, integration, and consistency of the
21 state-wide plan.

22 In establishing and implementing the state-wide health personnel
23 resource plan the committee shall, to the extent possible, utilize
24 existing data and information, personnel, equipment, and facilities and
25 shall minimize travel and take such other steps necessary to reduce the
26 administrative costs associated with the preparation and implementation
27 of the plan.

28 (2) The state-wide health resource plan shall include at least the
29 following:

30 (a)(i) Identification of the type, number, and location of the
31 health care professional work force necessary to meet health care needs
32 of the state.

33 (ii) A description and analysis of the composition and numbers of
34 the potential work force available for meeting health care service
35 needs of the population to be used for recruitment purposes. This
36 should include a description of the data, methodology, and process used
37 to make such determinations.

38 (b) A centralized inventory of the numbers of student applications
39 to higher education and vocational-technical training and education

1 programs, yearly enrollments, yearly degrees awarded, and numbers on
2 waiting lists for all the state's publicly funded health care training
3 and education programs. The committee shall request similar
4 information for incorporation into the inventory from private higher
5 education and vocational-technical training and education programs.

6 (c) A description of state-wide and local specialized provider
7 training needs to meet the health care needs of target populations and
8 a plan to meet such needs in a cost-effective and accessible manner.

9 (d) A description of how innovative, cost-effective technologies
10 such as telecommunications can and will be used to provide higher
11 education, vocational-technical, continued competency, and skill
12 maintenance and enhancement education and training to placebound
13 students who need flexible programs and who are unable to attend
14 institutions for training.

15 (e) A strategy for assuring higher education and vocational-
16 technical educational and training programming is sensitive to the
17 changing work force such as reentry workers, women, minorities, and the
18 disabled.

19 (f) Strategies to increase the number of persons of color in the
20 health professions. Such strategies shall incorporate, to the extent
21 possible, federal and state assistance programs for health career
22 development, including those for American Indians, economically
23 disadvantaged persons, physically challenged persons, and persons of
24 color.

25 (g) A strategy and coordinated state-wide policy developed by the
26 subcommittees authorized in subsection (1) of this section for
27 increasing the number of graduates intending to serve in shortage areas
28 after graduation, including such strategies as the establishment of
29 preferential admissions and designated enrollment slots.

30 (~~(g)~~) (h) Guidelines and policies developed by the subcommittees
31 authorized in subsection (1) of this section for allowing academic
32 credit for on-the-job experience such as internships, volunteer
33 experience, apprenticeships, and community service programs.

34 (~~(h)~~) (i) A strategy developed by the subcommittees authorized in
35 subsection (1) of this section for making required internships and
36 residency programs available that are geographically accessible and
37 sufficiently diverse to meet both general and specialized training
38 needs as identified in the plan when such programs are required.

1 (~~(i)~~) (j) A description of the need for multiskilled health care
2 professionals and an implementation plan to restructure educational and
3 training programming to meet these needs.

4 (~~(j)~~) (k) An analysis of the types and estimated numbers of
5 health care personnel that will need to be recruited from out-of-state
6 to meet the health professional needs not met by in-state trained
7 personnel.

8 (~~(k)~~) (l) An analysis of the need for educational articulation
9 within the various health care disciplines and a plan for addressing
10 the need.

11 (~~(l)~~) (m) An analysis of the training needs of those members of
12 the long-term care profession that are not regulated and that have no
13 formal training requirements. Programs to meet these needs should be
14 developed in a cost-effective and a state-wide accessible manner that
15 provide for the basic training needs of these individuals.

16 (~~(m)~~) (n) A designation of the professions and geographic
17 locations in which loan repayment and scholarships should be available
18 based upon objective data-based forecasts of health professional
19 shortages. A description of the criteria used to select professions
20 and geographic locations shall be included. Designations of
21 professions and geographic locations may be amended by the department
22 of health when circumstances warrant as provided for in RCW
23 28B.115.070.

24 (~~(n)~~) (o) A description of needed changes in regulatory laws
25 governing the credentialing of health professionals.

26 (~~(o)~~) (p) A description of linguistic and cultural training needs
27 of foreign-trained health care professionals to assure safe and
28 effective practice of their health care profession.

29 (~~(p)~~) (q) A plan to implement the recommendations of the state-
30 wide nursing plan authorized by RCW 74.39.040.

31 (~~(q)~~) (r) A description of criteria and standards that
32 institutional plans provided for in this section must address in order
33 to meet the requirements of the state-wide health personnel resource
34 plan, including funding requirements to implement the plans. The
35 committee shall also when practical identify specific outcome measures
36 to measure progress in meeting the requirements of this plan. The
37 criteria and standards shall be established in a manner as to provide
38 flexibility to the institutions in meeting state-wide plan
39 requirements. The committee shall establish required submission dates

1 for the institutional plans that permit inclusion of funding requests
2 into the institutions budget requests to the state.

3 ((~~r~~)) (s) A description of how the higher education coordinating
4 board, state board for community (~~college education~~) and technical
5 colleges, superintendent of public instruction, department of health,
6 and department of social and health services coordinated in the
7 creation and implementation of the state plan including the areas of
8 responsibility each agency shall assume. The plan should also include
9 a description of the steps taken to assure participation by the groups
10 that are to be consulted with.

11 ((~~s~~)) (t) A description of the estimated fiscal requirements for
12 implementation of the state-wide health resource plan that include a
13 description of cost saving activities that reduce potential costs by
14 avoiding administrative duplication, coordinating programming
15 activities, and other such actions to control costs.

16 (3) The committee may call upon other agencies of the state to
17 provide available information to assist the committee in meeting the
18 responsibilities under this chapter. This information shall be
19 supplied as promptly as circumstances permit.

20 (4) State agencies involved in the development and implementation
21 of the plan shall to the extent possible utilize existing personnel and
22 financial resources in the development and implementation of the state-
23 wide health personnel resource plan.

24 (5) The state-wide health personnel resource plan shall be
25 submitted to the governor by July 1, 1992, and updated by July 1 of
26 each even-numbered year. The governor, no later than December 1 of
27 that year, shall approve, approve with modifications, or disapprove the
28 state-wide health resource plan.

29 (6) The approved state-wide health resource plan shall be submitted
30 to the senate and house of representatives committees on health care,
31 higher education, and ways and means or appropriations by December 1 of
32 each even-numbered year.

33 (7) Implementation of the state-wide plan shall begin by July 1,
34 1993.

35 (8) Notwithstanding subsections (5) and (7) of this section, the
36 committee shall prepare and submit to the higher education coordinating
37 board by June 1, 1992, the analysis necessary for the initial
38 implementation of the health professional loan repayment and
39 scholarship program created in chapter 28B.115 RCW.

1 (9) Each publicly funded two-year and four-year institute of higher
2 education authorized under Title 28B RCW and vocational-technical
3 institution authorized under Title 28A RCW that offers health training
4 and education programs shall biennially prepare and submit an
5 institutional plan to the committee. The institutional plan shall
6 identify specific programming and activities of the institution that
7 meet the requirements of the state-wide health professional resource
8 plan.

9 The committee shall review and assess whether the institutional
10 plans meet the requirements of the state-wide health personnel resource
11 plan and shall prepare a report with its determination. The report
12 shall become part of the institutional plan and shall be submitted to
13 the governor and the legislature.

14 The institutional plan shall be included with the institution's
15 biennial budget submission. The institution's budget shall identify
16 proposed spending to meet the requirements of the institutional plan.
17 Each vocational-technical institution, college, or university shall be
18 responsible for implementing its institutional plan.

19 **Sec. 271.** RCW 28B.115.080 and 1991 c 332 s 21 are each amended to
20 read as follows:

21 ANNUAL AWARD AMOUNT. After June 1, 1992, the board, in
22 consultation with the department and the department of social and
23 health services, shall:

24 (1) Establish the annual award amount for each credentialed health
25 care profession which shall be based upon an assessment of reasonable
26 annual eligible expenses involved in training and education for each
27 credentialed health care profession. The annual award amount may be
28 established at a level less than annual eligible expenses. The annual
29 award amount shall ~~((not be more than fifteen thousand dollars per
30 year))~~ be established by the board for each eligible health profession.
31 The awards shall not be paid for more than a maximum of five years per
32 individual;

33 (2) Determine any scholarship awards for prospective physicians in
34 such a manner to require the recipients declare an interest in serving
35 in rural areas of the state of Washington. Preference for scholarships
36 shall be given to students who reside in a rural physician shortage
37 area or a nonshortage rural area of the state prior to admission to the
38 eligible education and training program in medicine. Highest

1 preference shall be given to students seeking admission who are
2 recommended by sponsoring communities and who declare the intent of
3 serving as a physician in a rural area. The board may require the
4 sponsoring community located in a nonshortage rural area to financially
5 contribute to the eligible expenses of a medical student if the student
6 will serve in the nonshortage rural area;

7 (3) Establish the required service obligation for each credentialed
8 health care profession, which shall be no less than three years or no
9 more than five years. The required service obligation may be based
10 upon the amount of the scholarship or loan repayment award such that
11 higher awards involve longer service obligations on behalf of the
12 participant;

13 (4) Determine eligible education and training programs for purposes
14 of the scholarship portion of the program;

15 (5) Honor loan repayment and scholarship contract terms negotiated
16 between the board and participants prior to May 21, 1991, concerning
17 loan repayment and scholarship award amounts and service obligations
18 authorized under chapter ((18.150)) 28B.115, 28B.104, or 70.180 RCW.

19 NEW SECTION. **Sec. 272.** A new section is added to chapter 41.05
20 RCW to read as follows:

21 MULTICULTURAL HEALTH CARE TECHNICAL ASSISTANCE PROGRAM. (1)
22 Consistent with funds appropriated specifically for this purpose, the
23 authority shall provide matching grants to support community-based
24 multicultural health care technical assistance programs. The purpose
25 of the programs shall be to promote technical assistance through
26 community and migrant health clinics and other appropriate health care
27 providers who serve underserved populations and persons of color.

28 The technical assistance provided shall include, but is not limited
29 to: (a) Collaborative research and data analysis on health care
30 outcomes that disproportionately affect persons of color; (b) design
31 and development of model health education and promotion strategies
32 aimed at modifying unhealthy health behaviors or enhancing the use of
33 the health care delivery system by persons of color; (c) provision of
34 technical information and assistance on program planning and financial
35 management; (d) administration, public policy development, and analysis
36 in health care issues affecting people of color; and (e) enhancement
37 and promotion of health care career opportunities for persons of color.

1 (2) Consistent with appropriated funds, the programs shall be
2 available on a state-wide basis.

3 **Sec. 273.** RCW 70.185.030 and 1991 c 332 s 9 are each amended to
4 read as follows:

5 COMMUNITY-BASED RECRUITMENT AND RETENTION--UNDERSERVED URBAN AREAS.

6 (1) The department (~~((shall))~~) may, subject to funding, establish (~~((up to~~
7 ~~three))~~) community-based recruitment and retention project sites to
8 provide financial and technical assistance to participating
9 communities. The goal of the project is to help assure the
10 availability of health care providers in rural and underserved urban
11 areas of Washington state.

12 (2) Administrative costs necessary to implement this project shall
13 be kept at a minimum to insure the maximum availability of funds for
14 participants.

15 (3) The secretary may contract with third parties for services
16 necessary to carry out activities to implement this chapter where this
17 will promote economy, avoid duplication of effort, and make the best
18 use of available expertise.

19 (4) The secretary may apply for, receive, and accept gifts and
20 other payments, including property and service, from any governmental
21 or other public or private entity or person, and may make arrangements
22 as to the use of these receipts, including the undertaking of special
23 studies and other projects related to the delivery of health care in
24 rural areas.

25 (5) In designing and implementing the project the secretary shall
26 coordinate (~~((the project))~~) and avoid duplication with similar federal
27 programs and with the Washington rural health system project as
28 authorized under chapter 70.175 RCW to consolidate administrative
29 duties and reduce costs.

30 NEW SECTION. **Sec. 274.** A new section is added to chapter 70.185
31 RCW to read as follows:

32 STUDENT POSITIONS. (1) The department may develop a mechanism for
33 underserved rural or urban communities to contract with education and
34 training programs for student positions above the full time equivalent
35 lids. The goal of this program is to provide additional capacity,
36 educating students who will practice in underserved communities.

1 (2) Eligible education and training programs are those programs
2 approved by the department that lead to eligibility for a credential as
3 a credentialed health care professional. Eligible professions are
4 those licensed under chapters 18.36A, 18.57, 18.57A, 18.71, and 18.71A
5 RCW and advanced registered nurse practitioners and certified nurse
6 midwives licensed under chapter 18.88 RCW, and may include other
7 providers identified as needed in the health personnel resource plan.

8 (3) Students participating in the community contracted educational
9 positions shall meet all applicable educational program requirements
10 and provide assurances, acceptable to the community, that they will
11 practice in the sponsoring community following completion of education
12 and necessary licensure.

13 (4) Participants in the program incur an obligation to repay any
14 contracted funds with interest set by state law, unless they serve at
15 least three years in the sponsoring community.

16 (5) The department may provide funds to communities for use in
17 contracting.

18 NEW SECTION. **Sec. 275.** A new section is added to chapter 70.185
19 RCW to read as follows:

20 AREA HEALTH EDUCATION CENTERS. The secretary may establish and
21 contract with area health education centers in the eastern and western
22 parts of the state. Consistent with the recruitment and retention
23 objectives of this chapter, the centers shall provide or facilitate the
24 provision of health professional educational and continuing education
25 programs that strengthen the delivery of primary health care services
26 in rural and medically underserved urban areas of the state. The
27 center shall assist in the development and operation of health
28 personnel recruitment and retention programs that are consistent with
29 activities authorized under this chapter. The centers shall further
30 provide technical expertise in the development of well managed health
31 care delivery systems in rural Washington consistent with the goals and
32 objectives of chapter . . . , Laws of 1993 (this act).

33 **Sec. 276.** RCW 43.70.460 and 1992 c 113 s 2 are each amended to
34 read as follows:

35 RETIRED PRIMARY CARE PROVIDERS--MALPRACTICE INSURANCE. (1) The
36 department may establish a program to purchase and maintain liability
37 malpractice insurance for retired (~~(physicians)~~) primary care providers

1 who provide primary health care services at community clinics. The
2 following conditions apply to the program:

3 (a) Primary health care services shall be provided at community
4 clinics that are public or private tax-exempt corporations;

5 (b) Primary health care services provided at the clinics shall be
6 offered to low-income patients based on their ability to pay;

7 (c) Retired (~~((physicians))~~) primary care providers providing health
8 care services shall not receive compensation for their services; and

9 (d) The department shall contract only with a liability insurer
10 authorized to offer liability malpractice insurance in the state.

11 (2) This section and RCW 43.70.470 shall not be interpreted to
12 require a liability insurer to provide coverage to a (~~((physician))~~)
13 primary care provider should the insurer determine that coverage should
14 not be offered to a physician because of past claims experience or for
15 other appropriate reasons.

16 (3) The state and its employees who operate the program shall be
17 immune from any civil or criminal action involving claims against
18 clinics or physicians that provided health care services under this
19 section and RCW 43.70.470. This protection of immunity shall not
20 extend to any clinic or (~~((physician))~~) primary care provider
21 participating in the program.

22 (4) The department may monitor the claims experience of retired
23 physicians covered by liability insurers contracting with the
24 department.

25 (5) The department may provide liability insurance under chapter
26 113, Laws of 1992 only to the extent funds are provided for this
27 purpose by the legislature.

28 **Sec. 277.** RCW 43.70.470 and 1992 c 113 s 3 are each amended to
29 read as follows:

30 RETIRED PRIMARY CARE PROVIDERS--CONDITIONS. The department may
31 establish by rule the conditions of participation in the liability
32 insurance program by retired (~~((physicians))~~) primary care providers at
33 clinics utilizing retired physicians for the purposes of this section
34 and RCW 43.70.460. These conditions shall include, but not be limited
35 to, the following:

36 (1) The participating (~~((physieian))~~) primary care provider
37 associated with the clinic shall hold a valid license to practice
38 (~~((medicine and surgery in this state and otherwise))~~) as a physician

1 under chapter 18.71 or 18.57 RCW, a naturopath under chapter 18.36A
2 RCW, a physician assistant under chapter 18.71A or 18.57A RCW, an
3 advanced registered nurse practitioner under chapter 18.88 RCW, a
4 dentist under chapter 18.32 RCW, or other health professionals as may
5 be deemed in short supply in the health personnel resource plan under
6 chapter 28B.125 RCW. All primary care providers must be in conformity
7 with current requirements for licensure as a retired ((physician))
8 primary care provider, including continuing education requirements;

9 (2) The participating ((physician)) primary care provider shall
10 limit the scope of practice in the clinic to primary care. Primary
11 care shall be limited to noninvasive procedures and shall not include
12 obstetrical care, or any specialized care and treatment. Noninvasive
13 procedures include injections, suturing of minor lacerations, and
14 incisions of boils or superficial abscesses. Primary dental care shall
15 be limited to diagnosis, oral hygiene, restoration, and extractions and
16 shall not include orthodontia, or other specialized care and treatment;

17 (3) The provision of liability insurance coverage shall not extend
18 to acts outside the scope of rendering medical services pursuant to
19 this section and RCW 43.70.460;

20 (4) The participating ((physician)) primary care provider shall
21 limit the provision of health care services to primarily low-income
22 persons provided that clinics may, but are not required to, provide
23 means tests for eligibility as a condition for obtaining health care
24 services;

25 (5) The participating ((physician)) primary care provider shall not
26 accept compensation for providing health care services from patients
27 served pursuant to this section and RCW 43.70.460, nor from clinics
28 serving these patients. "Compensation" shall mean any remuneration of
29 value to the participating ((physician)) primary care provider for
30 services provided by the ((physician)) primary care provider, but shall
31 not be construed to include any nominal copayments charged by the
32 clinic, nor reimbursement of related expenses of a participating
33 ((physician)) primary care provider authorized by the clinic in advance
34 of being incurred; and

35 (6) The use of mediation or arbitration for resolving questions of
36 potential liability may be used, however any mediation or arbitration
37 agreement format shall be expressed in terms clear enough for a person
38 with a sixth grade level of education to understand, and on a form no
39 longer than one page in length.

1 NEW SECTION. **Sec. 278.** MEDICAL SCHOOL GRADUATES SERVING IN RURAL
2 AND MEDICALLY UNDERSERVED AREAS OF THE STATE--LEGISLATIVE INTENT. The
3 legislature finds that the shortage of primary care physicians
4 practicing in rural and medically underserved areas of the state has
5 created a severe public health and safety problem. If unaddressed,
6 this problem is expected to worsen with health care reform since an
7 increased demand for primary care services will only contribute further
8 to these shortages.

9 The legislature further finds that the medical training program at
10 the University of Washington is an important and well respected
11 resource to the people of this state in the training of primary care
12 physicians. Currently, only a small proportion of medical school
13 graduates are Washington residents who serve as primary care
14 practitioners in certain parts of this state.

15 NEW SECTION. **Sec. 279.** MEDICAL SCHOOL PRIMARY CARE PHYSICIAN
16 SHORTAGE PLAN DEVELOPMENT. (1) The University of Washington shall
17 prepare a primary care shortage plan that accomplishes the following:

18 (a) Identifies specific activities that the school of medicine
19 shall pursue to increase the number of Washington residents serving as
20 primary care physicians in rural and medically underserved areas of the
21 state, including establishing a goal that assures that no less than
22 fifty percent of medical school graduates who are Washington state
23 residents at the time of matriculation will enter into primary care
24 residencies, to the extent possible, in Washington state by the year
25 2000;

26 (b) Assures that the school of medicine shall establish among its
27 highest training priorities the distribution of its primary care
28 physician graduates from the school and associated postgraduate
29 residency programs into rural and medically underserved areas;

30 (c) Establishes the goal of assuring that the annual number of
31 graduates from the family practice residency network entering rural or
32 medically underserved practice shall be increased by forty percent over
33 a baseline period from 1988 through 1990 by 1995;

34 (d) Establishes a further goal to make operational at least two
35 additional family practice residency programs within Washington state
36 in geographic areas identified by the plan as underserved in family
37 practice by 1997. The geographic areas identified by the plan as being
38 underserved by family practice physicians shall be consistent with any

1 such similar designations as may be made in the health personnel
2 research plan as authorized under chapter 28B.125 RCW;

3 (e) Establishes, with the cooperation of existing community and
4 migrant health clinics in rural or medically underserved areas of the
5 state, three family practice residency training tracks. Furthermore,
6 the primary care shortage plan shall provide that one of these training
7 tracks shall be a joint American osteopathic association and American
8 medical association approved training site coordinated with an
9 accredited college of osteopathic medicine with extensive experience in
10 training primary care physicians for the western United States. Such
11 a proposed joint accredited training track will have at least fifty
12 percent of its residency positions in osteopathic medicine; and

13 (f) Implements the plan, with the exception of the expansion of the
14 family practice residency network, within current biennial
15 appropriations for the University of Washington school of medicine.

16 (2) The plan shall be submitted to the appropriate committees of
17 the legislature no later than December 1, 1993.

18 I. SHORT-TERM HEALTH INSURANCE REFORM

19 NEW SECTION. **Sec. 280.** INTENT--INCREASE ACCESS TO COVERAGE. The
20 legislature intends that, during the transition to a fully reformed
21 health services system, certain health insurance practices be modified
22 to increase access to health insurance coverage for some individuals
23 and groups. The legislature recognizes that health insurance reform
24 will not remedy the significant lack of access to coverage in
25 Washington state without the implementation of strong cost control
26 measures. The authority granted to the commissioner in chapter . . . ,
27 Laws of 1993 (this act) is in addition to any authority the
28 commissioner currently has under Title 48 RCW to regulate insurers,
29 health care service contractors, and health maintenance organizations.

30 NEW SECTION. **Sec. 281.** A new section is added to chapter 48.18
31 RCW to read as follows:

32 CANCELLATIONS, DENIALS--WRITTEN COMMUNICATION. Every insurer upon
33 canceling, denying, or refusing to renew any disability policy, shall,
34 upon written request, directly notify in writing the applicant or
35 insured, as the case may be, of the reasons for the action by the
36 insurer and to any person covered under a group contract. Any

1 benefits, terms, rates, or conditions of such a contract that are
2 restricted, excluded, modified, increased, or reduced shall, upon
3 written request, be set forth in writing and supplied to the insured
4 and to any person covered under a group contract. The written
5 communications required by this section shall be phrased in simple
6 language that is readily understandable to a person of average
7 intelligence, education, and reading ability.

8 **Sec. 282.** RCW 48.21.200 and 1983 c 202 s 16 and 1983 c 106 s 24
9 are each reenacted and amended to read as follows:

10 REDUCTIONS OR REFUSAL OF BENEFITS. (1) No individual or group
11 disability insurance policy, health care service contract, or health
12 maintenance agreement which provides benefits for hospital, medical, or
13 surgical expenses shall be delivered or issued for delivery in this
14 state (~~((after September 8, 1975))~~) which contains any provision whereby
15 the insurer, contractor, or health maintenance organization may reduce
16 or refuse to pay such benefits otherwise payable thereunder solely on
17 account of the existence of similar benefits provided under any
18 (~~((individual))~~) disability insurance policy, (~~((or under any individual))~~)
19 health care service contract, or health maintenance agreement.

20 (2) No individual or group disability insurance policy, health care
21 service contract, or health maintenance agreement providing hospital,
22 medical or surgical expense benefits and which contains a provision for
23 the reduction of benefits otherwise payable or available thereunder on
24 the basis of other existing coverages, shall provide that such
25 reduction will operate to reduce total benefits payable below an amount
26 equal to one hundred percent of total allowable expenses exclusive of
27 copayments, deductibles, and other similar cost-sharing arrangements.

28 (3) The commissioner shall by rule establish guidelines for the
29 application of this section, including:

30 (a) The procedures by which persons (~~((insured))~~) covered under such
31 policies, contracts, and agreements are to be made aware of the
32 existence of such a provision;

33 (b) The benefits which may be subject to such a provision;

34 (c) The effect of such a provision on the benefits provided;

35 (d) Establishment of the order of benefit determination; ((and))

36 (e) Exceptions necessary to preserve policy, contract, or agreement
37 requirements for use of particular health care facilities or providers;
38 and

1 (f) Reasonable claim administration procedures to expedite claim
2 payments and prevent duplication of payments or benefits under such a
3 provision(~~(: PROVIDED, HOWEVER, That any group disability insurance~~
4 ~~policy which is issued as part of an employee insurance benefit program~~
5 ~~authorized by RCW 41.05.025(3) may exclude all or part of any~~
6 ~~deductible amounts from the definition of total allowable expenses for~~
7 ~~purposes of coordination of benefits within the plan and between such~~
8 ~~plan and other applicable group coverages: AND PROVIDED FURTHER, That~~
9 ~~any group disability insurance policy providing coverage for persons in~~
10 ~~this state may exclude all or part of any deductible amounts required~~
11 ~~by a group disability insurance policy from the definition of total~~
12 ~~allowable expenses for purposes of coordination of benefits between~~
13 ~~such policy and a group disability insurance policy issued as part of~~
14 ~~an employee insurance benefit program authorized by RCW 41.05.025(3).~~

15 ~~(3) The provisions of this section shall apply to health care~~
16 ~~service contractor contracts and health maintenance organization~~
17 ~~agreements)).~~

18 NEW SECTION. Sec. 283. A new section is added to chapter 48.20
19 RCW to read as follows:

20 DISABILITY INSURER--PREEXISTING CONDITIONS EXCLUSIONS AND
21 LIMITATIONS. (1) After January 1, 1994, every disability insurer
22 issuing coverage against loss arising from medical, surgical, hospital,
23 or emergency care coverage shall waive any preexisting condition
24 exclusion or limitation for persons who had similar coverage under a
25 different policy, health care service contract, or health maintenance
26 agreement in the three-month period immediately preceding the effective
27 date of coverage under the new policy to the extent that such person
28 has satisfied a waiting period under such preceding policy, contract,
29 or agreement; however, if the person satisfied a twelve-month waiting
30 period under such preceding policy, contract, or agreement, the insurer
31 shall waive any preexisting condition exclusion or limitation. The
32 insurer need not waive a preexisting condition exclusion or limitation
33 under the new policy for coverage not provided under such preceding
34 policy, contract, or agreement.

35 (2) The commissioner may adopt rules establishing guidelines for
36 determining when coverage is similar under new and preceding policies,
37 contracts, and agreements and for determining when a preexisting
38 condition waiting period has been satisfied.

1 (3) The commissioner in consultation with insurers, health care
2 service contractors, and health maintenance organizations shall study
3 the effect of preexisting condition exclusions and limitations on the
4 cost and availability of health care coverage and shall adopt rules
5 restricting the use of such conditions and limitations by January 1,
6 1994. No insurer, health care service contractor, or health
7 maintenance organization may deny, exclude, or limit coverage for
8 preexisting conditions for a period longer than that provided for in
9 such rules after July 1, 1994.

10 NEW SECTION. **Sec. 284.** A new section is added to chapter 48.21
11 RCW to read as follows:

12 GROUP DISABILITY INSURERS--PREEXISTING CONDITIONS EXCLUSIONS AND
13 LIMITATIONS. (1) After January 1, 1994, every disability insurer
14 issuing coverage against loss arising from medical, surgical, hospital,
15 or emergency care coverage shall waive any preexisting condition
16 exclusion or limitation for persons who had similar coverage under a
17 different policy, health care service contract, or health maintenance
18 agreement in the three-month period immediately preceding the effective
19 date of coverage under the new policy to the extent that such person
20 has satisfied a waiting period under such preceding policy, contract,
21 or agreement; however, if the person satisfied a twelve-month waiting
22 period under such preceding policy, contract, or agreement, the insurer
23 shall waive any preexisting condition exclusion or limitation. The
24 insurer need not waive a preexisting condition exclusion or limitation
25 under the new policy for coverage not provided under such preceding
26 policy, contract, or agreement.

27 (2) The commissioner may adopt rules establishing guidelines for
28 determining when coverage is similar under new and preceding policies,
29 contracts, and agreements and for determining when a preexisting
30 condition waiting period has been satisfied.

31 (3) The commissioner in consultation with insurers, health care
32 service contractors, and health maintenance organizations shall study
33 the effect of preexisting condition exclusions and limitations on the
34 cost and availability of health care coverage and shall adopt rules
35 restricting the use of such conditions and limitations by January 1,
36 1994. No insurer, health care service contractor, or health
37 maintenance organization may deny, exclude, or limit coverage for

1 preexisting conditions for a period longer than that provided for in
2 such rules after July 1, 1994.

3 NEW SECTION. **Sec. 285.** A new section is added to chapter 48.44
4 RCW to read as follows:

5 HEALTH CARE SERVICE CONTRACTORS--PREEXISTING CONDITIONS EXCLUSIONS
6 AND LIMITATIONS. (1) After January 1, 1994, every health care service
7 contractor, except limited health care service contractors as defined
8 under RCW 48.44.035, shall waive any preexisting condition exclusion or
9 limitation for persons who had similar coverage under a different
10 policy, health care service contract, or health maintenance agreement
11 in the three-month period immediately preceding the effective date of
12 coverage under the new contract to the extent that such person has
13 satisfied a waiting period under such preceding policy, contract, or
14 agreement; however, if the person satisfied a twelve-month waiting
15 period under such preceding policy, contract, or agreement, the insurer
16 shall waive any preexisting condition exclusion or limitation. The
17 insurer need not waive a preexisting condition exclusion or limitation
18 under the new policy for coverage not provided under such preceding
19 policy, contract, or agreement.

20 (2) The commissioner may adopt rules establishing guidelines for
21 determining when coverage is similar under new and preceding policies,
22 contracts, and agreements and for determining when a preexisting
23 condition waiting period has been satisfied.

24 (3) The commissioner in consultation with insurers, health care
25 service contractors, and health maintenance organizations shall study
26 the effect of preexisting condition exclusions and limitations on the
27 cost and availability of health care coverage and shall adopt rules
28 restricting the use of such conditions and limitations by January 1,
29 1994. No insurer, health care service contractor, or health
30 maintenance organization may deny, exclude, or limit coverage for
31 preexisting conditions for a period longer than that provided for in
32 such rules after July 1, 1994.

33 NEW SECTION. **Sec. 286.** A new section is added to chapter 48.46
34 RCW to read as follows:

35 HEALTH MAINTENANCE ORGANIZATIONS--PREEXISTING CONDITIONS EXCLUSIONS
36 AND LIMITATIONS. (1) After January 1, 1994, every health maintenance
37 organization shall waive any preexisting condition exclusion or

1 limitation for persons who had similar coverage under a different
2 policy, health care service contract, or health maintenance agreement
3 in the three-month period immediately preceding the effective date of
4 coverage under the new agreement to the extent that such person has
5 satisfied a waiting period under such preceding policy, contract, or
6 agreement; however, if the person satisfied a twelve-month waiting
7 period under such preceding policy, contract, or agreement, the insurer
8 shall waive any preexisting condition exclusion or limitation. The
9 insurer need not waive a preexisting condition exclusion or limitation
10 under the new policy for coverage not provided under such preceding
11 policy, contract, or agreement.

12 (2) The commissioner may adopt rules establishing guidelines for
13 determining when coverage is similar under new and preceding policies,
14 contracts, and agreements and for determining when a preexisting
15 condition waiting period has been satisfied.

16 (3) The commissioner in consultation with insurers, health care
17 service contractors, and health maintenance organizations shall study
18 the effect of preexisting condition exclusions and limitations on the
19 cost and availability of health care coverage and shall adopt rules
20 restricting the use of such conditions and limitations by January 1,
21 1994. No insurer, health care service contractor, or health
22 maintenance organization may deny, exclude, or limit coverage for
23 preexisting conditions for a period longer than that provided for in
24 such rules after July 1, 1994.

25 **Sec. 287.** RCW 48.30.300 and 1975-'76 2nd ex.s. c 119 s 7 are each
26 amended to read as follows:

27 UNFAIR PRACTICES. Notwithstanding any provision contained in Title
28 48 RCW to the contrary:

29 (1) No person or entity engaged in the business of insurance in
30 this state shall refuse to issue any contract of insurance or cancel or
31 decline to renew such contract because of the sex or marital status, or
32 the presence of any sensory, mental, or physical handicap of the
33 insured or prospective insured. The amount of benefits payable, or any
34 term, rate, condition, or type of coverage shall not be restricted,
35 modified, excluded, increased or reduced on the basis of the sex or
36 marital status, or be restricted, modified, excluded or reduced on the
37 basis of the presence of any sensory, mental, or physical handicap of
38 the insured or prospective insured. Subject to the provisions of

1 subsection (2) of this section these provisions shall not prohibit fair
2 discrimination on the basis of sex, or marital status, or the presence
3 of any sensory, mental, or physical handicap when bona fide statistical
4 differences in risk or exposure have been substantiated.

5 (2) With respect to disability policies issued or renewed on and
6 after July 1, 1994, that provide coverage against loss arising from
7 medical, surgical, hospital, or emergency care services:

8 (a) Policies shall guarantee continuity of coverage. Such
9 provision, which shall be included in every policy, shall provide that:

10 (i) The policy may be canceled or nonrenewed without the prior
11 written approval of the commissioner only for nonpayment of premium or
12 as permitted under RCW 48.18.090; and

13 (ii) The policy may be canceled or nonrenewed because of a change
14 in the physical or mental condition or health of a covered person only
15 with the prior written approval of the commissioner. Such approval
16 shall be granted only when the insurer has discharged its obligation to
17 continue coverage for such person by obtaining coverage with another
18 insurer, health care service contractor, or health maintenance
19 organization, which coverage is comparable in terms of premiums and
20 benefits as defined by rule of the commissioner.

21 (b) It is an unfair practice for a disability insurer to modify the
22 coverage provided or rates applying to an in-force disability insurance
23 policy and to fail to make such modification in all such issued and
24 outstanding policies.

25 (c) Subject to rules adopted by the commissioner, it is an unfair
26 practice for a disability insurer to:

27 (i) Cease the sale of a policy form unless it has received prior
28 written authorization from the commissioner and has offered all
29 policyholders covered under such discontinued policy the opportunity to
30 purchase comparable coverage without health screening; or

31 (ii) Engage in a practice that subjects policyholders to rate
32 increases on discontinued policy forms unless such policyholders are
33 offered the opportunity to purchase comparable coverage without health
34 screening.

35 The insurer may limit an offer of comparable coverage without
36 health screening to a period not less than thirty days from the date
37 the offer is first made.

1 NEW SECTION. **Sec. 288.** A new section is added to chapter 48.44
2 RCW to read as follows:

3 HEALTH CARE SERVICE CONTRACTS--UNFAIR PRACTICES. (1) With respect
4 to all health care service contracts issued or renewed on and after
5 July 1, 1994, except limited health care service contracts as defined
6 in RCW 48.44.035:

7 (a) Contracts shall guarantee continuity of coverage. Such
8 provision, which shall be included in every contract, shall provide
9 that:

10 (i) The contract may be canceled or nonrenewed without the prior
11 written approval of the commissioner only for nonpayment of premiums,
12 for violation of published policies of the contractor that have been
13 approved by the commissioner, for persons who are entitled to become
14 eligible for medicare benefits and fail to subscribe to a medicare
15 supplement plan offered by the contractor, for failure of such
16 subscriber to pay any deductible or copayment amount owed to the
17 contractor and not the provider of health care services, for fraud, or
18 for a material breach of the contract; and

19 (ii) The contract may be canceled or nonrenewed because of a change
20 in the physical or mental condition or health of a covered person only
21 with the prior written approval of the commissioner. Such approval
22 shall be granted only when the contractor has discharged its obligation
23 to continue coverage for such person by obtaining coverage with another
24 insurer, health care service contractor, or health maintenance
25 organization, which coverage is comparable in terms of premiums and
26 benefits as defined by rule of the commissioner.

27 (b) It is an unfair practice for a contractor to modify the
28 coverage provided or rates applying to an in-force contract and to fail
29 to make such modification in all such issued and outstanding contracts.

30 (c) Subject to rules adopted by the commissioner, it is an unfair
31 practice for a health care service contractor to:

32 (i) Cease the sale of a contract form unless it has received prior
33 written authorization from the commissioner and has offered all
34 subscribers covered under such discontinued contract the opportunity to
35 purchase comparable coverage without health screening; or

36 (ii) Engage in a practice that subjects subscribers to rate
37 increases on discontinued contract forms unless such subscribers are
38 offered the opportunity to purchase comparable coverage without health
39 screening.

1 (2) The health care service contractor may limit an offer of
2 comparable coverage without health screening to a period not less than
3 thirty days from the date the offer is first made.

4 NEW SECTION. **Sec. 289.** A new section is added to chapter 48.46
5 RCW to read as follows:

6 HEALTH MAINTENANCE AGREEMENTS--UNFAIR PRACTICES. (1) With respect
7 to all health maintenance agreements issued or renewed on and after
8 July 1, 1994, and in addition to the restrictions and limitations
9 contained in RCW 48.46.060(4):

10 (a) Agreements shall guarantee continuity of coverage. Such
11 provision, which shall be included in every agreement, shall provide
12 that the agreement may be canceled or nonrenewed because of a change in
13 the physical or mental condition or health of a covered person only
14 with the prior written approval of the commissioner. Such approval
15 shall be granted only when the organization has discharged its
16 obligation to continue coverage for such person by obtaining coverage
17 with another insurer, health care service contractor, or health
18 maintenance organization, which coverage is comparable in terms of
19 premiums and benefits as defined by rule of the commissioner.

20 (b) It is an unfair practice for an organization to modify the
21 coverage provided or rates applying to an in-force agreement and to
22 fail to make such modification in all such issued and outstanding
23 agreements.

24 (c) Subject to rules adopted by the commissioner, it is an unfair
25 practice for a health maintenance organization to:

26 (i) Cease the sale of an agreement form unless it has received
27 prior written authorization from the commissioner and has offered all
28 enrollees covered under such discontinued agreement the opportunity to
29 purchase comparable coverage without health screening; or

30 (ii) Engage in a practice that subjects enrollees to rate increases
31 on discontinued agreement forms unless such enrollees are offered the
32 opportunity to purchase comparable coverage without health screening.

33 (2) The health maintenance organization may limit an offer of
34 comparable coverage without health screening to a period not less than
35 thirty days from the date the offer is first made.

36 **Sec. 290.** RCW 48.44.260 and 1979 c 133 s 3 are each amended to
37 read as follows:

1 HEALTH CARE SERVICE CONTRACTOR--NOTICE OF CANCELLATION. Every
2 authorized health care service contractor, upon canceling, denying, or
3 refusing to renew any individual health care service contract, shall,
4 upon written request, directly notify in writing the applicant or
5 ((insured)) subscriber, as the case may be, of the reasons for the
6 action by the health care service contractor. Any benefits, terms,
7 rates, or conditions of such a contract which are restricted, excluded,
8 modified, increased, or reduced ((because of the presence of a sensory,
9 mental, or physical handicap)) shall, upon written request, be set
10 forth in writing and supplied to the ((insured)) subscriber. The
11 written communications required by this section shall be phrased in
12 simple language which is readily understandable to a person of average
13 intelligence, education, and reading ability.

14 **Sec. 291.** RCW 48.46.380 and 1983 c 106 s 16 are each amended to
15 read as follows:

16 HEALTH MAINTENANCE ORGANIZATION--NOTICE OF CANCELLATIONS. Every
17 authorized health maintenance organization, upon canceling, denying, or
18 refusing to renew any individual health maintenance agreement, shall,
19 upon written request, directly notify in writing the applicant or
20 enrolled participant as appropriate, of the reasons for the action by
21 the health maintenance organization. Any benefits, terms, rates, or
22 conditions of such agreement which are restricted, excluded, modified,
23 increased, or reduced ((because of the presence of a sensory, mental,
24 or physical handicap)) shall, upon written request, be set forth in
25 writing and supplied to the individual. The written communications
26 required by this section shall be phrased in simple language which is
27 readily understandable to a person of average intelligence, education,
28 and reading ability.

29 NEW SECTION. **Sec. 292.** REPEALERS--REPORT; STUDIES. The following
30 acts or parts of acts are each repealed:

- 31 (1) RCW 48.46.160 and 1975 1st ex.s. c 290 s 17; and
32 (2) RCW 48.46.905 and 1975 1st ex.s. c 290 s 25.

33 NEW SECTION. **Sec. 293.** REPEALER--NONTERMINATION FOR CHANGE IN
34 HEALTH. RCW 48.44.410 and 1986 c 223 s 12 are each repealed, effective
35 July 1, 1994.

1 NEW SECTION. **Sec. 294.** A new section is added to chapter 48.01
2 RCW to read as follows:

3 CERTIFIED HEALTH PLAN PROVISIONS--APPLICATION. Whenever the
4 provisions of this title conflict with the provisions of chapter . . . ,
5 Laws of 1993 (this act), chapter . . . , Laws of 1993 (this act) shall
6 control.

7 **Sec. 295.** RCW 48.44.095 and 1983 c 202 s 3 are each amended to
8 read as follows:

9 ANNUAL STATEMENT. (1) Every health care service contractor shall
10 annually, (~~within one hundred twenty days of the closing date of its~~
11 ~~fiscal year~~) before the first day of March, file with the commissioner
12 a statement verified by at least two of the principal officers of the
13 health care service contractor showing its financial condition as of
14 the (~~closing date of its fiscal year~~) last day of the preceding
15 calendar year. The statement shall be in such form as is furnished or
16 prescribed by the commissioner. The commissioner may for good reason
17 allow a reasonable extension of the time within which such annual
18 statement shall be filed.

19 (2) The commissioner may suspend or revoke the certificate of
20 registration of any health care service contractor failing to file its
21 annual statement when due or during any extension of time therefor
22 which the commissioner, for good cause, may grant.

23 **Sec. 296.** RCW 48.46.080 and 1983 c 202 s 10 and 1983 c 106 s 6 are
24 each reenacted and amended to read as follows:

25 ANNUAL STATEMENT. (1) Every health maintenance organization shall
26 annually, (~~within one hundred twenty days of the closing date of its~~
27 ~~fiscal year~~) before the first day of March, file with the commissioner
28 a statement verified by at least two of the principal officers of the
29 health maintenance organization showing its financial condition as of
30 the (~~closing date of its fiscal year~~) last day of the preceding
31 calendar year.

32 (2) Such annual report shall be in such form as the commissioner
33 shall prescribe and shall include:

34 (a) A financial statement of such organization, including its
35 balance sheet and receipts and disbursements for the preceding year,
36 which reflects at a minimum;

1 (i) all prepayments and other payments received for health care
2 services rendered pursuant to health maintenance agreements;

3 (ii) expenditures to all categories of health care facilities,
4 providers, insurance companies, or hospital or medical service plan
5 corporations with which such organization has contracted to fulfill
6 obligations to enrolled participants arising out of its health
7 maintenance agreements, together with all other direct expenses
8 including depreciation, enrollment, and commission; and

9 (iii) expenditures for capital improvements, or additions thereto,
10 including but not limited to construction, renovation, or purchase of
11 facilities and capital equipment;

12 (b) The number of participants enrolled and terminated during the
13 report period. Every employer offering health care benefits to their
14 employees through a group contract with a health maintenance
15 organization shall furnish said health maintenance organization with a
16 list of their employees enrolled under such plan;

17 (c) The number of doctors by type of practice who, under contract
18 with or as an employee of the health maintenance organization,
19 furnished health care services to consumers during the past year;

20 (d) A report of the names and addresses of all officers, directors,
21 or trustees of the health maintenance organization during the preceding
22 year, and the amount of wages, expense reimbursements, or other
23 payments to such individuals for services to such organization. For
24 partnership and professional service corporations, a report shall be
25 made for partners or shareholders as to any compensation or expense
26 reimbursement received by them for services, other than for services
27 and expenses relating directly for patient care;

28 (e) Such other information relating to the performance of the
29 health maintenance organization or the health care facilities or
30 providers with which it has contracted as reasonably necessary to the
31 proper and effective administration of this chapter, in accordance with
32 rules and regulations; and

33 (f) Disclosure of any financial interests held by officers and
34 directors in any providers associated with the health maintenance
35 organization or any provider of the health maintenance organization.

36 (3) The commissioner may for good reason allow a reasonable
37 extension of the time within which such annual statement shall be
38 filed.

1 (4) The commissioner may suspend or revoke the certificate of
2 registration of any health maintenance organization failing to file its
3 annual statement when due or during any extension of time therefor
4 which the commissioner, for good cause, may grant.

5 (5) No person shall knowingly file with any public official or
6 knowingly make, publish, or disseminate any financial statement of a
7 health maintenance organization which does not accurately state the
8 health maintenance organization's financial condition.

9 **PART III. TAXES**

10 NEW SECTION. **Sec. 301.** A new section is added to chapter 48.14
11 RCW to read as follows:

12 TAX ON PREMIUMS AND PREPAYMENTS. (1) As used in this section,
13 "taxpayer" means a health maintenance organization, as defined in RCW
14 48.46.020, a health care service contractor, as defined in RCW
15 48.44.010, or a certified health plan certified under section 434 of
16 this act.

17 (2) Each taxpayer shall pay a tax on or before the first day of
18 March of each year to the state treasurer through the insurance
19 commissioner's office. The tax shall be equal to the total amount of
20 all premiums and prepayments for health care services received by the
21 taxpayer during the preceding calendar year multiplied by the rate of
22 two percent.

23 (3) Taxpayers shall prepay their tax obligations under this
24 section. The minimum amount of the prepayments shall be percentages of
25 the taxpayer's tax obligation for the preceding calendar year
26 recomputed using the rate in effect for the current year. For the
27 prepayment of taxes due during the first calendar year, the minimum
28 amount of the prepayments shall be percentages of the taxpayer's tax
29 obligation that would have been due had the tax been in effect during
30 the previous calendar year. The tax prepayments shall be paid to the
31 state treasurer through the commissioner's office by the due dates and
32 in the following amounts:

33 (a) On or before June 15, forty-five percent;

34 (b) On or before September 15, twenty-five percent;

35 (c) On or before December 15, twenty-five percent.

36 (4) For good cause demonstrated in writing, the commissioner may
37 approve an amount smaller than the preceding calendar year's tax

1 obligation as recomputed for calculating the health maintenance
2 organization's prepayment obligations for the current tax year.

3 (5) Moneys collected under this section shall be deposited in the
4 health services account under section 469 of this act.

5 (6) The taxes imposed in this section do not apply to:

6 (a) Amounts received by any taxpayer from the United States or any
7 instrumentality thereof as prepayments for health care services
8 provided under Title XVIII (medicare) of the federal social security
9 act. This exemption shall expire July 1, 1997.

10 (b) Amounts received by any health care service contractor, as
11 defined in RCW 48.44.010, as prepayments for health care services
12 included within the definition of practice of dentistry under RCW
13 18.32.020. This exemption does not apply to amounts received under a
14 certified health plan certified under section 434 of this act.

15 **Sec. 302.** RCW 48.14.080 and 1949 c 190 s 21 are each amended to
16 read as follows:

17 PREMIUM TAX IN LIEU OF OTHER FORMS. As to insurers other than
18 title insurers, the taxes imposed by this title shall be in lieu of all
19 other taxes, except taxes on real and tangible personal property
20 (~~and~~), excise taxes on the sale, purchase or use of such property,
21 and the tax imposed in RCW 82.04.260(15).

22 NEW SECTION. **Sec. 303.** A new section is added to chapter 82.04
23 RCW to read as follows:

24 EXEMPTION FROM BUSINESS AND OCCUPATION TAX. This chapter does not
25 apply to any health maintenance organization, health care service
26 contractor, or certified health plan in respect to premiums or
27 prepayments that are taxable under section 301 of this act.

28 **Sec. 304.** RCW 82.04.260 and 1991 c 272 s 15 are each amended to
29 read as follows:

30 TAX ON HOSPITALS OPERATED AS NONPROFIT CORPORATIONS. (1) Upon
31 every person engaging within this state in the business of buying
32 wheat, oats, dry peas, dry beans, lentils, triticale, corn, rye and
33 barley, but not including any manufactured or processed products
34 thereof, and selling the same at wholesale; the tax imposed shall be
35 equal to the gross proceeds derived from such sales multiplied by the
36 rate of one one-hundredth of one percent.

1 (2) Upon every person engaging within this state in the business of
2 manufacturing wheat into flour, barley into pearl barley, soybeans into
3 soybean oil, or sunflower seeds into sunflower oil; as to such persons
4 the amount of tax with respect to such business shall be equal to the
5 value of the flour, pearl barley, or oil manufactured, multiplied by
6 the rate of one-eighth of one percent.

7 (3) Upon every person engaging within this state in the business of
8 splitting or processing dried peas; as to such persons the amount of
9 tax with respect to such business shall be equal to the value of the
10 peas split or processed, multiplied by the rate of one-quarter of one
11 percent.

12 (4) Upon every person engaging within this state in the business of
13 manufacturing seafood products which remain in a raw, raw frozen, or
14 raw salted state at the completion of the manufacturing by that person;
15 as to such persons the amount of tax with respect to such business
16 shall be equal to the value of the products manufactured, multiplied by
17 the rate of one-eighth of one percent.

18 (5) Upon every person engaging within this state in the business of
19 manufacturing by canning, preserving, freezing or dehydrating fresh
20 fruits and vegetables; as to such persons the amount of tax with
21 respect to such business shall be equal to the value of the products
22 canned, preserved, frozen or dehydrated multiplied by the rate of
23 three-tenths of one percent.

24 (6) Upon every nonprofit corporation and nonprofit association
25 engaging within this state in research and development, as to such
26 corporations and associations, the amount of tax with respect to such
27 activities shall be equal to the gross income derived from such
28 activities multiplied by the rate of forty-four one-hundredths of one
29 percent.

30 (7) Upon every person engaging within this state in the business of
31 slaughtering, breaking and/or processing perishable meat products
32 and/or selling the same at wholesale only and not at retail; as to such
33 persons the tax imposed shall be equal to the gross proceeds derived
34 from such sales multiplied by the rate of twenty-five one-hundredths of
35 one percent through June 30, 1986, and one-eighth of one percent
36 thereafter.

37 (8) Upon every person engaging within this state in the business of
38 making sales, at retail or wholesale, of nuclear fuel assemblies
39 manufactured by that person, as to such persons the amount of tax with

1 respect to such business shall be equal to the gross proceeds of sales
2 of the assemblies multiplied by the rate of twenty-five one-hundredths
3 of one percent.

4 (9) Upon every person engaging within this state in the business of
5 manufacturing nuclear fuel assemblies, as to such persons the amount of
6 tax with respect to such business shall be equal to the value of the
7 products manufactured multiplied by the rate of twenty-five one-
8 hundredths of one percent.

9 (10) Upon every person engaging within this state in the business
10 of acting as a travel agent; as to such persons the amount of the tax
11 with respect to such activities shall be equal to the gross income
12 derived from such activities multiplied by the rate of twenty-five one-
13 hundredths of one percent.

14 (11) Upon every person engaging within this state in business as an
15 international steamship agent, international customs house broker,
16 international freight forwarder, vessel and/or cargo charter broker in
17 foreign commerce, and/or international air cargo agent; as to such
18 persons the amount of the tax with respect to only international
19 activities shall be equal to the gross income derived from such
20 activities multiplied by the rate of thirty-three one-hundredths of one
21 percent.

22 (12) Upon every person engaging within this state in the business
23 of stevedoring and associated activities pertinent to the movement of
24 goods and commodities in waterborne interstate or foreign commerce; as
25 to such persons the amount of tax with respect to such business shall
26 be equal to the gross proceeds derived from such activities multiplied
27 by the rate of thirty-three one hundredths of one percent. Persons
28 subject to taxation under this subsection shall be exempt from payment
29 of taxes imposed by chapter 82.16 RCW for that portion of their
30 business subject to taxation under this subsection. Stevedoring and
31 associated activities pertinent to the conduct of goods and commodities
32 in waterborne interstate or foreign commerce are defined as all
33 activities of a labor, service or transportation nature whereby cargo
34 may be loaded or unloaded to or from vessels or barges, passing over,
35 onto or under a wharf, pier, or similar structure; cargo may be moved
36 to a warehouse or similar holding or storage yard or area to await
37 further movement in import or export or may move to a consolidation
38 freight station and be stuffed, unstuffed, containerized, separated or
39 otherwise segregated or aggregated for delivery or loaded on any mode

1 of transportation for delivery to its consignee. Specific activities
2 included in this definition are: Wharfage, handling, loading,
3 unloading, moving of cargo to a convenient place of delivery to the
4 consignee or a convenient place for further movement to export mode;
5 documentation services in connection with the receipt, delivery,
6 checking, care, custody and control of cargo required in the transfer
7 of cargo; imported automobile handling prior to delivery to consignee;
8 terminal stevedoring and incidental vessel services, including but not
9 limited to plugging and unplugging refrigerator service to containers,
10 trailers, and other refrigerated cargo receptacles, and securing ship
11 hatch covers.

12 (13) Upon every person engaging within this state in the business
13 of disposing of low-level waste, as defined in RCW 43.145.010; as to
14 such persons the amount of the tax with respect to such business shall
15 be equal to the gross income of the business, excluding any fees
16 imposed under chapter 43.200 RCW, multiplied by the rate of fifteen
17 percent.

18 (a) The rate specified in this subsection shall be reduced to ten
19 percent on May 20, 1991.

20 (b) The rate specified in this subsection shall be further reduced
21 to five percent on January 1, 1992.

22 (c) The rate specified in this subsection shall be further reduced
23 to three percent on July 1, 1993.

24 If the gross income of the taxpayer is attributable to activities
25 both within and without this state, the gross income attributable to
26 this state shall be determined in accordance with the methods of
27 apportionment required under RCW 82.04.460.

28 (14) Upon every person engaging within this state as an insurance
29 agent, insurance broker, or insurance solicitor licensed under chapter
30 48.17 RCW; as to such persons, the amount of the tax with respect to
31 such licensed activities shall be equal to the gross income of such
32 business multiplied by the rate of one percent.

33 (15) Upon every person engaging within this state in business as a
34 hospital, as defined in chapter 70.41 RCW, that is operated as a
35 nonprofit corporation, as to such persons, the amount of tax with
36 respect to such activities shall be equal to the gross income of the
37 business multiplied by the rate of seventy-five one-hundredths of one
38 percent through June 30, 1995, and one and five-tenths percent
39 thereafter. The moneys collected under this subsection shall be

1 deposited in the health services account created under section 469 of
2 this act.

3 **Sec. 305.** RCW 82.04.4289 and 1981 c 178 s 2 are each amended to
4 read as follows:

5 HOSPITAL EXEMPTION DELETED. (~~In computing tax there may be~~
6 ~~deducted from the measure of tax~~) This chapter does not apply to
7 amounts derived as compensation for services rendered to patients or
8 from sales of prescription drugs as defined in RCW 82.08.0281 furnished
9 as an integral part of services rendered to patients by (~~a hospital,~~
10 ~~as defined in chapter 70.41 RCW, which is operated as a nonprofit~~
11 ~~corporation,~~) a kidney dialysis facility operated as a nonprofit
12 corporation, (~~whether or not operated in connection with a hospital,~~)
13 nursing homes, and homes for unwed mothers operated as religious or
14 charitable organizations, but only if no part of the net earnings
15 received by such an institution inures directly or indirectly, to any
16 person other than the institution entitled to deduction hereunder.
17 (~~In no event shall any such deduction be allowed, unless the hospital~~
18 ~~building is entitled to exemption from taxation under the property tax~~
19 ~~laws of this state.~~)

20 NEW SECTION. **Sec. 306.** REPEALER--BUSINESS AND OCCUPATION TAX
21 DEDUCTION FOR PUBLICLY OPERATED HOSPITALS. RCW 82.04.4288 and 1980 c
22 37 s 9 are each repealed.

23 **Sec. 307.** RCW 82.24.020 and 1989 c 271 s 504 are each amended to
24 read as follows:

25 TAX ON CIGARETTES. (1) There is levied and there shall be
26 collected as (~~hereinafter~~) provided in this chapter, a tax upon the
27 sale, use, consumption, handling, possession or distribution of all
28 cigarettes, in an amount equal to the rate of eleven and one-half mills
29 per cigarette.

30 (2) Until July 1, 1995, an additional tax is imposed upon the sale,
31 use, consumption, handling, possession, or distribution of all
32 cigarettes, in an amount equal to the rate of one and one-half mills
33 per cigarette. All revenues collected during any month from this
34 additional tax shall be deposited in the drug enforcement and education
35 account under RCW 69.50.520 by the twenty-fifth day of the following
36 month.

1 (3) An additional tax is imposed upon the sale, use, consumption,
2 handling, possession, or distribution of all cigarettes, in an amount
3 equal to the rate of ten mills per cigarette through June 30, 1994,
4 eleven and one-fourth mills per cigarette for the period July 1, 1994,
5 through June 30, 1995, twenty mills per cigarette for the period July
6 1, 1995, through June 30, 1996, and twenty and one-half mills per
7 cigarette thereafter. All revenues collected during any month from
8 this additional tax shall be deposited in the health services account
9 created under section 469 of this act by the twenty-fifth day of the
10 following month.

11 (4) Wholesalers and retailers subject to the payment of this tax
12 may, if they wish, absorb one-half mill per cigarette of the tax and
13 not pass it on to purchasers without being in violation of this section
14 or any other act relating to the sale or taxation of cigarettes.

15 ~~((4))~~ (5) For purposes of this chapter, "possession" shall mean
16 both (a) physical possession by the purchaser and, (b) when cigarettes
17 are being transported to or held for the purchaser or his or her
18 designee by a person other than the purchaser, constructive possession
19 by the purchaser or his designee, which constructive possession shall
20 be deemed to occur at the location of the cigarettes being so
21 transported or held.

22 **Sec. 308.** RCW 82.24.080 and 1972 ex.s. c 157 s 4 are each amended
23 to read as follows:

24 TAX LIABILITY--CIGARETTE TAX. It is the intent and purpose of this
25 chapter to levy a tax on all of the articles taxed ~~((herein))~~ under
26 this chapter, sold, used, consumed, handled, possessed, or distributed
27 within this state and to collect the tax from the person who first
28 sells, uses, consumes, handles, possesses (either physically or
29 constructively, in accordance with RCW 82.24.020) or distributes them
30 in the state. It is further the intent and purpose of this chapter
31 that whenever any of the articles ~~((herein))~~ taxed under this chapter
32 is given away for advertising or any other purpose, it shall be taxed
33 in the same manner as if it were sold, used, consumed, handled,
34 possessed, or distributed in this state.

35 It is also the intent and purpose of this chapter that the tax
36 shall be imposed at the time and place of the first taxable event
37 occurring within this state~~((:—PROVIDED, HOWEVER, That))~~. Failure to

1 pay the tax with respect to a taxable event shall not prevent tax
2 liability from arising by reason of a subsequent taxable event.

3 In the event of an increase in the rate of the tax imposed under
4 this chapter, it is the intent of the legislature that the first person
5 who sells, uses, consumes, handles, possesses, or distributes
6 previously taxed articles after the effective date of the rate increase
7 shall be liable for the additional tax represented by the rate
8 increase, but the failure to pay the additional tax with respect to the
9 first taxable event after the effective date of a rate increase shall
10 not prevent tax liability for the additional tax from arising from a
11 subsequent taxable event.

12 **Sec. 309.** RCW 82.26.020 and 1983 2nd ex.s. c 3 s 16 are each
13 amended to read as follows:

14 TAX ON TOBACCO PRODUCTS. (1) (~~From and after June 1, 1971,~~)
15 There is levied and there shall be collected a tax upon the sale, use,
16 consumption, handling, or distribution of all tobacco products in this
17 state at the rate of forty-five percent of the wholesale sales price of
18 such tobacco products. (~~Such tax~~)

19 (2) Taxes under this section shall be imposed at the time the
20 distributor (a) brings, or causes to be brought, into this state from
21 without the state tobacco products for sale, (b) makes, manufactures,
22 or fabricates tobacco products in this state for sale in this state, or
23 (c) ships or transports tobacco products to retailers in this state, to
24 be sold by those retailers.

25 (~~(+2)~~) (3) An additional tax is imposed equal to (~~the rate~~
26 ~~specified in RCW 82.02.030~~) seven percent multiplied by the tax
27 payable under subsection (1) of this section.

28 (4) An additional tax is imposed equal to ten percent of the
29 wholesale sales price of tobacco products. The moneys collected under
30 this subsection shall be deposited in the health services account
31 created under section 469 of this act.

32 **Sec. 310.** RCW 82.08.150 and 1989 c 271 s 503 are each amended to
33 read as follows:

34 TAX ON SPIRITS. (1) There is levied and shall be collected a tax
35 upon each retail sale of spirits, or strong beer in the original
36 package at the rate of fifteen percent of the selling price. The tax
37 imposed in this subsection shall apply to all such sales including

1 sales by the Washington state liquor stores and agencies, but excluding
2 sales to class H licensees.

3 (2) There is levied and shall be collected a tax upon each sale of
4 spirits, or strong beer in the original package at the rate of ten
5 percent of the selling price on sales by Washington state liquor stores
6 and agencies to class H licensees.

7 (3) There is levied and shall be collected an additional tax upon
8 each retail sale of spirits in the original package at the rate of one
9 dollar and seventy-two cents per liter. The additional tax imposed in
10 this subsection shall apply to all such sales including sales by
11 Washington state liquor stores and agencies, and including sales to
12 class H licensees.

13 (4) An additional tax is imposed equal to (~~the rate specified in~~
14 ~~RCW 82.02.030~~) fourteen percent multiplied by the taxes payable under
15 subsections (1), (2), and (3) of this section.

16 (5) Until July 1, 1995, an additional tax is imposed upon each
17 retail sale of spirits in the original package at the rate of seven
18 cents per liter. The additional tax imposed in this subsection shall
19 apply to all such sales including sales by Washington state liquor
20 stores and agencies, and including sales to class H licensees. All
21 revenues collected during any month from this additional tax shall be
22 deposited in the drug enforcement and education account under RCW
23 69.50.520 by the twenty-fifth day of the following month.

24 (6)(a) An additional tax is imposed upon retail sale of spirits in
25 the original package at the rate of one and seven-tenths percent of the
26 selling price through June 30, 1995, two and six-tenths percent of the
27 selling price for the period July 1, 1995, through June 30, 1997, and
28 three and four-tenths of the selling price thereafter. This additional
29 tax applies to all such sales including sales by Washington state
30 liquor stores and agencies, but excluding sales to class H licensees.

31 (b) An additional tax is imposed upon retail sale of spirits in the
32 original package at the rate of one and one-tenth percent of the
33 selling price through June 30, 1995, one and seven-tenths percent of
34 the selling price for the period July 1, 1995, through June 30, 1997,
35 and two and three-tenths of the selling price thereafter. This
36 additional tax applies to all such sales to class H licensees.

37 (c) An additional tax is imposed upon each retail sale of spirits
38 in the original package at the rate of twenty cents per liter through
39 June 30, 1995, thirty cents per liter for the period July 1, 1995,

1 through June 30, 1997, and forty-one cents per liter thereafter. This
2 additional tax applies to all such sales including sales by Washington
3 state liquor stores and agencies, and including sales to class H
4 licensees.

5 (d) All revenues collected during any month from additional taxes
6 under this subsection shall be deposited in the health services account
7 created under section 469 of this act by the twenty-fifth day of the
8 following month.

9 (7) The tax imposed in RCW 82.08.020(~~as now or hereafter~~
10 ~~amended~~)) shall not apply to sales of spirits or strong beer in the
11 original package.

12 ~~((+7))~~ (8) The taxes imposed in this section shall be paid by the
13 buyer to the seller, and each seller shall collect from the buyer the
14 full amount of the tax payable in respect to each taxable sale under
15 this section. The taxes required by this section to be collected by
16 the seller shall be stated separately from the selling price and for
17 purposes of determining the tax due from the buyer to the seller, it
18 shall be conclusively presumed that the selling price quoted in any
19 price list does not include the taxes imposed by this section.

20 ~~((+8))~~ (9) As used in this section, the terms, "spirits," "strong
21 beer," and "package" shall have the meaning ascribed to them in chapter
22 66.04 RCW.

23 **Sec. 311.** RCW 66.24.290 and 1989 c 271 s 502 are each amended to
24 read as follows:

25 TAX ON BEER--REDUCED RATE FOR CERTAIN BREWERIES. (1) Any brewer or
26 beer wholesaler licensed under this title may sell and deliver beer to
27 holders of authorized licenses direct, but to no other person, other
28 than the board; and every such brewer or beer wholesaler shall report
29 all sales to the board monthly, pursuant to the regulations, and shall
30 pay to the board as an added tax for the privilege of manufacturing and
31 selling the beer within the state a tax of two dollars and sixty cents
32 per barrel of thirty-one gallons on sales to licensees within the state
33 and on sales to licensees within the state of bottled and canned beer
34 shall pay a tax computed in gallons at the rate of two dollars and
35 sixty cents per barrel of thirty-one gallons. Any brewer or beer
36 wholesaler whose applicable tax payment is not postmarked by the
37 twentieth day following the month of sale will be assessed a penalty at
38 the rate of two percent per month or fraction thereof. Each such

1 brewer or wholesaler shall procure from the board revenue stamps
2 representing such tax in form prescribed by the board and shall affix
3 the same to the barrel or package in such manner and in such
4 denominations as required by the board, and shall cancel the same prior
5 to commencing delivery from his or her place of business or warehouse
6 of such barrels or packages. Beer shall be sold by brewers and
7 wholesalers in sealed barrels or packages. The revenue stamps
8 ~~((herein))~~ provided ~~((for))~~ under this section need not be affixed and
9 canceled in the making of resales of barrels or packages already taxed
10 by the affixation and cancellation of stamps as provided in this
11 section.

12 (2) An additional tax is imposed equal to ~~((the rate specified in~~
13 ~~RCW 82.02.030))~~ seven percent multiplied by the tax payable under
14 subsection (1) of this section. All revenues collected during any
15 month from this additional tax shall be transferred to the state
16 general fund by the twenty-fifth day of the following month.

17 (3) Until July 1, 1995, an additional tax is imposed on all beer
18 subject to tax under subsection (1) of this section. The additional
19 tax is equal to two dollars per barrel of thirty-one gallons. All
20 revenues collected during any month from this additional tax shall be
21 deposited in the drug enforcement and education account under RCW
22 69.50.520 by the twenty-fifth day of the following month.

23 (4)(a) An additional tax is imposed on all beer subject to tax
24 under subsection (1) of this section. The additional tax is equal to
25 ninety-six cents per barrel of thirty-one gallons through June 30,
26 1995, two dollars and thirty-nine cents per barrel of thirty-one
27 gallons for the period July 1, 1995, through June 30, 1997, and four
28 dollars and seventy-eight cents per barrel of thirty-one gallons
29 thereafter.

30 (b) The additional tax imposed under this subsection does not apply
31 to the sale of the first sixty thousand barrels of beer each year by
32 breweries that are entitled to a reduced rate of tax under 26 U.S.C.
33 Sec. 5051, as existing on the effective date of this section or such
34 subsequent date as may be provided by the board by rule consistent with
35 the purposes of this exemption.

36 (c) All revenues collected from the additional tax imposed under
37 this subsection (4) shall be deposited in the health services account
38 under section 469 of this act.

1 (5) "Continuous quality improvement and total quality management"
2 means a continuous process to improve health services while reducing
3 costs.

4 (6) "Employee" means a resident who is in the employment of an
5 employer, as defined by chapter 50.04 RCW.

6 (7) "Enrollee" means any person who is a Washington resident
7 enrolled in a certified health plan.

8 (8) "Enrollee point of service cost-sharing" means amounts paid to
9 certified health plans directly providing services, health care
10 providers, or health care facilities by enrollees for receipt of
11 specific uniform benefits package services, and may include copayments,
12 coinsurance, or deductibles, that together must be actuarially
13 equivalent across plans and within overall limits established by the
14 commission.

15 (9) "Enrollee premium sharing" means that portion of the premium
16 that is paid by enrollees or their family members.

17 (10) "Federal poverty level" means the federal poverty guidelines
18 determined annually by the United States department of health and human
19 services or successor agency.

20 (11) "Health care facility" or "facility" means hospices licensed
21 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
22 rural health facilities as defined in RCW 70.175.020, psychiatric
23 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
24 under chapter 18.51 RCW, community mental health centers licensed under
25 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
26 under chapter 70.41 RCW, ambulatory diagnostic, treatment or surgical
27 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
28 facilities licensed under chapter 70.96A RCW, and home health agencies
29 licensed under chapter 70.127 RCW, and includes such facilities if
30 owned and operated by a political subdivision or instrumentality of the
31 state and such other facilities as required by federal law and
32 implementing regulations, but does not include Christian Science
33 sanatoriums operated, listed, or certified by the First Church of
34 Christ Scientist, Boston, Massachusetts.

35 (12) "Health care provider" or "provider" means:

36 (a) A person regulated under Title 18 RCW and chapter 70.127 RCW,
37 to practice health or health-related services or otherwise practicing
38 health care services in this state consistent with state law; or

1 (b) An employee or agent of a person described in (a) of this
2 subsection, acting in the course and scope of his or her employment.

3 (13) "Health insurance purchasing cooperative" or "cooperative"
4 means a member-owned and governed nonprofit organization certified in
5 accordance with sections 425 and 426 of this act.

6 (14) "Long-term care" means institutional, residential, outpatient,
7 or community-based services that meet the individual needs of persons
8 of all ages who are limited in their functional capacities or have
9 disabilities and require assistance with performing two or more
10 activities of daily living for an extended or indefinite period of
11 time. These services include case management, protective supervision,
12 in-home care, nursing services, convalescent, custodial, chronic, and
13 terminally ill care.

14 (15) "Major capital expenditure" means any project or expenditure
15 for capital construction, renovations, or acquisition, including
16 medical technological equipment, as defined by the commission, costing
17 more than one million dollars.

18 (16) "Managed care" means an integrated system of insurance,
19 financing, and health services delivery functions that: (a) Assumes
20 financial risk for delivery of health services and uses a defined
21 network of providers; or (b) assumes financial risk for delivery of
22 health services and promotes the efficient delivery of health services
23 through provider assumption of some financial risk including
24 capitation, prospective payment, resource-based relative value scales,
25 fee schedules, or similar method of limiting payments to health care
26 providers.

27 (17) "Maximum enrollee financial participation" means the income-
28 related total annual payments that may be required of an enrollee per
29 family who chooses one of the three lowest priced uniform benefits
30 packages offered by plans in a geographic region including both premium
31 sharing and enrollee point of service cost-sharing.

32 (18) "Persons of color" means Asians/Pacific Islanders, African,
33 Hispanic, and Native Americans.

34 (19) "Premium" means all sums charged, received, or deposited by a
35 certified health plan as consideration for a uniform benefits package
36 or the continuance of a uniform benefits package. Any assessment, or
37 any "membership," "policy," "contract," "service," or similar fee or
38 charge made by the certified health plan in consideration for the
39 uniform benefits package is deemed part of the premium. "Premium"

1 shall not include amounts paid as enrollee point of service cost-
2 sharing.

3 (20) "Qualified employee" means an employee who is employed at
4 least thirty hours during a week or one hundred twenty hours during a
5 calendar month.

6 (21) "Registered employer health plan" means a health plan
7 established by a private employer of more than seven thousand active
8 employees in this state solely for the benefit of such employees and
9 their dependents and that meets the requirements of section 430 of this
10 act. Nothing contained in this subsection shall be deemed to preclude
11 the plan from providing benefits to retirees of the employer.

12 (22) "Supplemental benefits" means those appropriate and effective
13 health services that are not included in the uniform benefits package
14 or that expand the type or level of health services available under the
15 uniform benefits package and that are offered to all residents in
16 accordance with the provisions of sections 452 and 453 of this act.

17 (23) "Technology" means the drugs, devices, equipment, and medical
18 or surgical procedures used in the delivery of health services, and the
19 organizational or supportive systems within which such services are
20 provided. It also means sophisticated and complicated machinery
21 developed as a result of ongoing research in the basic biological and
22 physical sciences, clinical medicine, electronics, and computer
23 sciences, as well as specialized professionals, medical equipment,
24 procedures, and chemical formulations used for both diagnostic and
25 therapeutic purposes.

26 (24) "Uniform benefits package" or "package" means those
27 appropriate and effective health services, defined by the commission
28 under section 449 of this act, that must be offered to all Washington
29 residents through certified health plans.

30 (25) "Washington resident" or "resident" means a person who intends
31 to reside in the state permanently or indefinitely and who did not move
32 to Washington for the primary purpose of securing health services under
33 sections 427 through 466 of this act. "Washington resident" also
34 includes people and their accompanying family members who are residing
35 in the state for the purpose of engaging in employment for at least one
36 month, who did not enter the state for the primary purpose of obtaining
37 health services. The confinement of a person in a nursing home,
38 hospital, or other medical institution in the state shall not by itself
39 be sufficient to qualify such person as a resident.

1 **A. THE WASHINGTON HEALTH SERVICES COMMISSION**

2 NEW SECTION. **Sec. 403.** CREATION OF COMMISSION--MEMBERSHIP--TERMS
3 OF OFFICE--VACANCIES--SALARIES. (1) There is created an agency of
4 state government to be known as the Washington health services
5 commission. The commission shall consist of five members reflecting
6 ethnic and racial diversity, appointed by the governor, with the
7 consent of the senate. One member shall be designated by the governor
8 as chair and shall serve at the pleasure of the governor. The
9 insurance commissioner shall serve as an additional nonvoting member.
10 Of the initial members, one shall be appointed to a term of three
11 years, two shall be appointed to a term of four years, and two shall be
12 appointed to a term of five years. Thereafter, members shall be
13 appointed to five-year terms. Vacancies shall be filled by appointment
14 for the remainder of the unexpired term of the position being vacated.

15 (2) Members of the commission shall have no pecuniary interest in
16 any business subject to regulation by the commission and shall be
17 subject to chapter 42.18 RCW, the executive branch conflict of interest
18 act.

19 (3) Members of the commission shall occupy their positions on a
20 full-time basis and are exempt from the provisions of chapter 41.06
21 RCW. Commission members and the professional commission staff are
22 subject to the public disclosure provisions of chapter 42.17 RCW.
23 Members shall be paid a salary to be fixed by the governor in
24 accordance with RCW 43.03.040. A majority of the members of the
25 commission constitutes a quorum for the conduct of business.

26 NEW SECTION. **Sec. 404.** ADVISORY COMMITTEES. (1)(a) The chair
27 shall appoint an advisory committee with balanced representation from
28 consumers, business, government, labor, certified health plans,
29 practicing health care providers, health care facilities, and health
30 services researchers reflecting ethnic and racial diversity. In
31 addition, the chair may appoint special committees for specified
32 periods of time.

33 (b) The chair shall also appoint a five-member health services
34 effectiveness committee whose members possess a breadth of experience
35 and knowledge in the treatment, research, and public and private
36 funding of health care services. The committee shall meet at the call
37 of the chair. The health services effectiveness committee shall advise

1 the commission on: (i) Those health services that may be determined by
2 the commission to be appropriate and effective; (ii) use of technology
3 and practice indicators; (iii) the uniform benefits package; and (iv)
4 rules that insurers and certified health plans must use to determine
5 whether a procedure, treatment, drug, or other health service is no
6 longer experimental or investigative.

7 (c) The commission shall also appoint a small business advisory
8 committee composed of seven owners of businesses with twenty-five or
9 fewer full-time equivalent employees' reflecting ethnic and racial
10 diversity, to assist the commission in development of the small
11 business economic impact statement and the small business assistance
12 program, as provided in sections 450 and 466 of this act.

13 (d) The commission shall also appoint an organized labor advisory
14 committee composed of seven representatives of employee organizations
15 representing employees of public or private employers. The committee
16 shall assist the commission in conducting the evaluation of Taft-
17 Hartley health care trusts and self-insured employee health benefits
18 plans, as provided in section 406(26) of this act, and shall advise the
19 commission on issues related to the impact of chapter . . . , Laws of
20 1993 (this act) on negotiated health benefits agreements and other
21 employee health benefits plans.

22 (2) Members of committees and panels shall serve without
23 compensation for their services but shall be reimbursed for their
24 expenses while attending meetings on behalf of the commission in
25 accordance with RCW 43.03.050 and 43.03.060.

26 NEW SECTION. **Sec. 405.** POWERS AND DUTIES OF THE CHAIR. The chair
27 shall be the chief administrative officer and the appointing authority
28 of the commission and has the following powers and duties:

29 (1) Direct and supervise the commission's administrative and
30 technical activities in accordance with the provisions of this chapter
31 and rules and policies adopted by the commission;

32 (2) Employ personnel of the commission in accordance with chapter
33 41.06 RCW, and prescribe their duties. With the approval of a majority
34 of the commission, the chair may appoint persons to administer any
35 entity established pursuant to subsection (8) of this section, and up
36 to seven additional employees all of whom shall be exempt from the
37 provisions of chapter 41.06 RCW;

38 (3) Enter into contracts on behalf of the commission;

1 (4) Accept and expend gifts, donations, grants, and other funds
2 received by the commission;

3 (5) Delegate administrative functions of the commission to
4 employees of the commission as the chair deems necessary to ensure
5 efficient administration;

6 (6) Subject to approval of the commission, appoint advisory
7 committees and undertake studies, research, and analysis necessary to
8 support activities of the commission;

9 (7) Preside at meetings of the commission;

10 (8) Consistent with policies and rules established by the
11 commission, establish such administrative divisions, offices, or
12 programs as are necessary to carry out the purposes of chapter . . . ,
13 Laws of 1993 (this act); and

14 (9) Perform such other administrative and technical duties as are
15 consistent with chapter . . . , Laws of 1993 (this act) and the rules
16 and policies of the commission.

17 NEW SECTION. **Sec. 406.** POWERS AND DUTIES OF THE COMMISSION. The
18 commission has the following powers and duties:

19 (1) Ensure that all residents of Washington state are enrolled in
20 a certified health plan to receive the uniform benefits package,
21 regardless of age, sex, family structure, ethnicity, race, health
22 condition, geographic location, employment, or economic status.

23 (2) Endeavor to ensure that all residents of Washington state have
24 access to appropriate, timely, confidential, and effective health
25 services, and monitor the degree of access to such services. If the
26 commission finds that individuals or populations lack access to
27 certified health plan services, the commission shall:

28 (a) Authorize appropriate state agencies, local health departments,
29 community or migrant health clinics, public hospital districts, or
30 other nonprofit health service entities to take actions necessary to
31 assure such access. This includes authority to contract for or
32 directly deliver services described within the uniform benefits package
33 to special populations; or

34 (b) Notify appropriate certified health plans and the insurance
35 commissioner of such findings. The commission shall adopt by rule
36 standards by which the insurance commissioner may, in such event,
37 require certified health plans in closest proximity to such individuals

1 and populations to extend their catchment areas to those individuals
2 and populations and offer them enrollment.

3 (3) Adopt necessary rules in accordance with chapter 34.05 RCW to
4 carry out the purposes of chapter . . . , Laws of 1993 (this act). An
5 initial set of draft rules establishing at least the commission's
6 organization structure, the uniform benefits package, and standards for
7 certified health plan certification, must be submitted in draft form to
8 appropriate committees of the legislature by December 1, 1994.

9 (4) Establish and modify as necessary, in consultation with the
10 state board of health and the department of health, and coordination
11 with the planning process set forth in section 467 of this act a
12 uniform set of health services based on the recommendations of the
13 health care cost control and access commission established under House
14 Concurrent Resolution No. 4443 adopted by the legislature in 1990.

15 (5) Establish and modify as necessary the uniform benefits package
16 as provided in section 449 of this act, which shall be offered to
17 enrollees of a certified health plan. The benefit package shall be
18 provided at no more than the maximum premium specified in subsection
19 (6) of this section.

20 (6)(a) Establish for each year a community-rated maximum premium
21 for the uniform benefits package that shall operate to control overall
22 health care costs. The maximum premium cost of the uniform benefits
23 package in the base year 1995 shall be established upon an actuarial
24 determination of the costs of providing the uniform benefits package
25 and such other cost impacts as may be deemed relevant by the
26 commission. Beginning in 1996, the growth rate of the premium cost of
27 the uniform benefits package for each certified health plan shall be
28 allowed to increase by a rate no greater than the average growth rate
29 in the cost of the package between 1990 and 1993 as actuarially
30 determined, reduced by two percentage points per year until the growth
31 rate is no greater than the five-year rolling average of growth in
32 Washington per capita personal income, as determined by the office of
33 financial management.

34 (b) In establishing the community-rated maximum premium under this
35 subsection, the commission shall develop a composite rate for employees
36 that provides nominal, if any, variance between the rate for individual
37 employees and employees with dependents to minimize any economic
38 incentive to an employer to discriminate between prospective employees
39 based upon whether or not they have dependents for whom coverage would

1 be required. Nothing in this subsection (6)(b) shall preclude the
2 commission from evaluating other methodologies for establishing the
3 community-rated maximum premium and recommending an alternative
4 methodology to the legislature.

5 (c) If the commission adds or deletes services or benefits to the
6 uniform benefits package in subsequent years, it may increase or
7 decrease the maximum premium to reflect the actual cost experience of
8 a broad sample of providers of that service in the state, considering
9 the factors enumerated in (a) of this subsection and adjusted
10 actuarially. The addition of services or benefits shall not result in
11 a redetermination of the entire cost of the uniform benefits package.

12 (d) The level of state expenditures for the uniform benefits
13 package shall be limited to the appropriation of funds specifically for
14 this purpose.

15 (7) Determine the need for medical risk adjustment mechanisms to
16 minimize financial incentives for certified health plans to enroll
17 individuals who present lower health risks and avoid enrolling
18 individuals who present higher health risks, and to minimize financial
19 incentives for employer hiring practices that discriminate against
20 individuals who present higher health risks. In the design of medical
21 risk distribution mechanisms under this subsection, the commission
22 shall (a) balance the benefits of price competition with the need to
23 protect certified health plans from any unsustainable negative effects
24 of adverse selection; (b) consider the development of a system that
25 creates a risk profile of each certified health plan's enrollee
26 population that does not create disincentives for a plan to control
27 benefit utilization, that requires contributions from plans that enjoy
28 a low-risk enrollee population to plans that have a high-risk enrollee
29 population, and that does not permit an adjustment of the premium
30 charged for the uniform benefits package or supplemental coverage based
31 upon either receipt or contribution of assessments; and (c) consider
32 whether registered employer health plans should be included in any
33 medical risk adjustment mechanism. Proposed medical risk adjustment
34 mechanisms shall be submitted to the legislature as provided in section
35 454 of this act.

36 (8) Design a mechanism to assure minors have access to confidential
37 health care services as currently provided in RCW 70.24.110 and
38 71.34.030.

1 (9) Monitor the actual growth in total annual health services
2 costs.

3 (10) Monitor the increased application of technology as required by
4 chapter . . . , Laws of 1993 (this act) and take necessary action to
5 ensure that such application is made in a cost-effective and efficient
6 manner and consistent with existing laws that protect individual
7 privacy.

8 (11) Establish reporting requirements for certified health plans
9 that own or manage health care facilities, health care facilities, and
10 health care providers to periodically report to the commission
11 regarding major capital expenditures of the plans. The commission
12 shall review and monitor such reports and shall report to the
13 legislature regarding major capital expenditures on at least an annual
14 basis. The Washington health care facilities authority and the
15 commission shall develop standards jointly for evaluating and approving
16 major capital expenditure financing through the Washington health care
17 facilities authority, as authorized pursuant to chapter 70.37 RCW. By
18 December 1, 1994, the commission and the authority shall submit jointly
19 to the legislature such proposed standards. The commission and the
20 authority shall, after legislative review, but no later than June 1,
21 1995, publish such standards. Upon publication, the authority may not
22 approve financing for major capital expenditures unless approved by the
23 commission.

24 (12) Establish maximum enrollee financial participation levels.
25 The levels shall be related to enrollee household income.

26 (13) For health services provided under the uniform benefits
27 package and supplemental benefits, adopt standards for enrollment, and
28 standardized billing and claims processing forms. The standards shall
29 ensure that these procedures minimize administrative burdens on health
30 care providers, health care facilities, certified health plans, and
31 consumers. Subject to federal approval or phase-in schedules whenever
32 necessary or appropriate, the standards also shall apply to state-
33 purchased health services, as defined in RCW 41.05.011.

34 (14) Propose that certified health plans adopt certain practice
35 indicators or risk management protocols for quality assurance,
36 utilization review, or provider payment. The commission may consider
37 indicators or protocols recommended according to section 410 of this
38 act for these purposes.

1 (15) Propose other guidelines to certified health plans for
2 utilization management, use of technology and methods of payment, such
3 as diagnosis-related groups and a resource-based relative value scale.
4 Such guidelines shall be voluntary and shall be designed to promote
5 improved management of care, and provide incentives for improved
6 efficiency and effectiveness within the delivery system.

7 (16) Adopt standards and oversee and develop policy for personal
8 health data and information system as provided in chapter 70.170 RCW.

9 (17) Adopt standards that prevent conflict of interest by health
10 care providers as provided in section 408 of this act.

11 (18) At the appropriate juncture and in the fullness of time,
12 consider the extent to which medical research and health professions
13 training activities should be included within the health service system
14 set forth in this chapter . . . , Laws of 1993 (this act).

15 (19) Evaluate and monitor the extent to which racial and ethnic
16 minorities have access and to receive health services within the state,
17 and develop strategies to address barriers to access.

18 (20) Develop standards for the certification process to certify
19 health plans and employer health plans to provide the uniform benefits
20 package, according to the provisions for certified health plans and
21 registered employer health plans under chapter . . . , Laws of 1993
22 (this act).

23 (21) Develop rules for implementation of individual and employer
24 participation under sections 463 and 464 of this act specifically
25 applicable to persons who work in this state but do not live in the
26 state or persons who live in this state but work outside of the state.
27 The rules shall be designed so that these persons receive coverage and
28 financial requirements that are comparable to that received by persons
29 who both live and work in the state.

30 (22) After receiving advice from the health services effectiveness
31 committee, adopt rules that must be used by certified health plans,
32 disability insurers, health care service contractors, and health
33 maintenance organizations to determine whether a procedure, treatment,
34 drug, or other health service is no longer experimental or
35 investigative.

36 (23) Establish a process for purchase of uniform benefits package
37 services by enrollees when they are out-of-state.

38 (24) Develop recommendations to the legislature as to whether state
39 and school district employees, on whose behalf health benefits are or

1 will be purchased by the health care authority pursuant to chapter
2 41.05 RCW, should have the option to purchase health benefits through
3 health insurance purchasing cooperatives on and after July 1, 1997. In
4 developing its recommendations, the commission shall consider:

5 (a) The impact of state or school district employees purchasing
6 through health insurance purchasing cooperatives on the ability of the
7 state to control its health care costs; and

8 (b) Whether state or school district employees purchasing through
9 health insurance purchasing cooperatives will result in inequities in
10 health benefits between or within groups of state and school district
11 employees.

12 (25) Establish guidelines for providers dealing with terminal or
13 static conditions, taking into consideration the ethics of providers,
14 patient and family wishes, costs, and survival possibilities.

15 (26) Evaluate the extent to which Taft-Hartley health care trusts
16 provide benefits to certain individuals in the state; review the
17 federal laws under which these trusts are organized; and make
18 appropriate recommendations to the governor and the legislature on or
19 before December 1, 1994, as to whether these trusts should be brought
20 under the provisions of chapter . . . , Laws of 1993 (this act) when it
21 is fully implemented, and if the commission recommends inclusion of the
22 trusts, how to implement such inclusion.

23 (27) Evaluate whether Washington is experiencing a higher
24 percentage in in-migration of residents from other states and
25 territories than would be expected by normal trends as a result of the
26 availability of unsubsidized and subsidized health care benefits for
27 all residents and report to the governor and the legislature their
28 findings.

29 (28) In developing the uniform benefits package and other standards
30 pursuant to this section, consider the likelihood of the establishment
31 of a national health services plan adopted by the federal government
32 and its implications.

33 (29) Evaluate the effect of reforms under chapter . . . , Laws of
34 1993 (this act) on access to care and economic development in rural
35 areas.

36 To the extent that the exercise of any of the powers and duties
37 specified in this section may be inconsistent with the powers and
38 duties of other state agencies, offices, or commissions, the authority
39 of the commission shall supersede that of such other state agency,

1 office, or commission, except in matters of personal health data, where
2 the commission shall have primary data system policymaking authority
3 and the department of health shall have primary responsibility for the
4 maintenance and routine operation of personal health data systems.

5 NEW SECTION. **Sec. 407.** MODIFICATION OF MAXIMUM PREMIUM. Upon the
6 recommendation of the insurance commissioner, and on the basis of
7 evidence established by independent actuarial analysis, if the
8 commission finds that the economic viability of a significant number of
9 the state's certified health plans is seriously threatened, the
10 commission may increase the maximum premium to the extent mandated by
11 the Constitution, and must immediately thereafter submit to the
12 legislature a proposal for a new formula for adjusting the maximum
13 premium, which must be enacted into law by a sixty percent vote of each
14 house of the legislature.

15 NEW SECTION. **Sec. 408.** A new section is added to chapter 18.130
16 RCW to read as follows:

17 CONFLICT OF INTEREST STANDARDS. The Washington health services
18 commission established by section 403 of this act, in consultation with
19 the secretary of health, and the health care disciplinary authorities
20 under RCW 18.130.040(2)(b), shall establish standards and monetary
21 penalties in rule prohibiting provider investments and referrals that
22 present a conflict of interest resulting from inappropriate financial
23 gain for the provider or his or her immediate family. These standards
24 are not intended to inhibit the efficient operation of managed health
25 care systems or certified health plans. The commission shall report to
26 the health policy committees of the senate and house of representatives
27 by December 1, 1994, on the development of the standards and any
28 recommended statutory changes necessary to implement the standards.

29 NEW SECTION. **Sec. 409.** CONTINUOUS QUALITY IMPROVEMENT AND TOTAL
30 QUALITY MANAGEMENT. To ensure the highest quality health services at
31 the lowest total cost, the commission shall establish a total quality
32 management system of continuous quality improvement. Such endeavor
33 shall be based upon the recognized quality science for continuous
34 quality improvement. The commission shall impanel a committee composed
35 of persons from the private sector and related sciences who have broad
36 knowledge and successful experiences in continuous quality improvement

1 and total quality management applications. It shall be the
2 responsibility of the committee to develop standards for a Washington
3 state health services supplier certification process and recommend such
4 standards to the commission for review and adoption. Once adopted, the
5 commission shall establish a schedule, with full compliance no later
6 than July 1, 1996, whereby all health service providers and health
7 service facilities shall be certified prior to providing uniform
8 benefits package services.

9

B. PRACTICE INDICATORS

10 NEW SECTION. **Sec. 410.** A new section is added to chapter 43.70
11 RCW to read as follows:

12 PRACTICE INDICATORS. The department of health shall consult with
13 health care providers and facilities, purchasers, health professional
14 regulatory authorities under RCW 18.130.040, appropriate research and
15 clinical experts, and consumers of health care services to identify
16 specific practice areas where practice indicators and risk management
17 protocols have been developed, including those that have been
18 demonstrated to be effective among persons of color. Practice
19 indicators shall be based upon expert consensus and best available
20 scientific evidence. The department shall:

21 (1) Develop a definition of expert consensus and best available
22 scientific evidence so that practice indicators can serve as a standard
23 for excellence in the provision of health care services.

24 (2) Establish a process to identify and evaluate practice
25 indicators and risk management protocols as they are developed by the
26 appropriate professional, scientific, and clinical communities.

27 (3) Recommend the use of practice indicators and risk management
28 protocols in quality assurance, utilization review, or provider payment
29 to the health services commission.

30

C. HEALTH CARE LIABILITY REFORMS

31 **Sec. 411.** RCW 43.70.320 and 1991 sp.s. c 13 s 18 are each amended
32 to read as follows:

33 HEALTH PROFESSIONS ACCOUNT. (1) There is created in the state
34 treasury an account to be known as the health professions account. All
35 fees received by the department for health professions licenses,

1 registration, certifications, renewals, or examinations and the civil
2 penalties assessed and collected by the department under RCW 18.130.190
3 shall be forwarded to the state treasurer who shall credit such moneys
4 to the health professions account.

5 (2) All expenses incurred in carrying out the health professions
6 licensing activities of the department shall be paid from the account
7 as authorized by legislative appropriation. Any residue in the account
8 shall be accumulated and shall not revert to the general fund at the
9 end of the biennium.

10 (3) The secretary shall biennially prepare a budget request based
11 on the anticipated costs of administering the health professions
12 licensing activities of the department which shall include the
13 estimated income from health professions fees.

14 NEW SECTION. Sec. 412. A new section is added to chapter 18.130
15 RCW to read as follows:

16 MALPRACTICE INSURANCE COVERAGE MANDATE. Except to the extent that
17 liability insurance is not available, every licensed health care
18 practitioner whose services are included in the uniform benefits
19 package, as determined by section 449 of this act, and whose scope of
20 practice includes independent practice, shall, as a condition of
21 licensure and relicensure, be required to provide evidence of a minimum
22 level of malpractice insurance coverage issued by a company authorized
23 to do business in this state. On or before January 1, 1994, the
24 department shall designate by rule:

25 (1) Those health professions whose scope of practice includes
26 independent practice;

27 (2) For each health profession whose scope of practice includes
28 independent practice, whether malpractice insurance is available; and

29 (3) If such insurance is available, the appropriate minimum level
30 of mandated coverage.

31 NEW SECTION. Sec. 413. A new section is added to chapter 48.22
32 RCW to read as follows:

33 RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS.
34 Effective July 1, 1994, a casualty insurer's issuance of a new medical
35 malpractice policy or renewal of an existing medical malpractice policy
36 to a physician or other independent health care practitioner shall be
37 conditioned upon that practitioner's participation in, and completion

1 of, an insurer-designed health care liability risk management training
2 program once every three years. The risk management training shall
3 provide information related to avoiding adverse health outcomes
4 resulting from substandard practice and minimizing damages associated
5 with the adverse health outcomes that do occur. For purposes of this
6 section, "independent health care practitioners" means those health
7 care practitioner licensing classifications designated by the
8 department of health in rule pursuant to section 412 of this act.

9 NEW SECTION. **Sec. 414.** A new section is added to chapter 48.05
10 RCW to read as follows:

11 RISK MANAGEMENT TRAINING OF INDEPENDENT HEALTH CARE PRACTITIONERS.
12 Effective July 1, 1994, each health care provider, facility, or health
13 maintenance organization that self-insures for liability risks related
14 to medical malpractice and employs physicians or other independent
15 health care practitioners in Washington state shall condition each
16 physician's and practitioner's liability coverage by that entity upon
17 that physician's or practitioner's participation in risk management
18 training offered by the provider, facility, or health maintenance
19 organization to its employees. The risk management training shall
20 provide information related to avoiding adverse health outcomes
21 resulting from substandard practice and minimizing damages associated
22 with those adverse health outcomes that do occur. For purposes of this
23 section, "independent health care practitioner" means those health care
24 practitioner licensing classifications designated by the department of
25 health in rule pursuant to section 412 of this act.

26 **Sec. 415.** RCW 70.41.200 and 1991 c 3 s 336 are each amended to
27 read as follows:

28 QUALITY IMPROVEMENT PROGRAM. (1) Every hospital shall maintain a
29 coordinated quality improvement program for the improvement of the
30 quality of health care services rendered to patients and the
31 identification and prevention of medical malpractice. The program
32 shall include at least the following:

33 (a) The establishment of a quality ((assurance)) improvement
34 committee with the responsibility to review the services rendered in
35 the hospital, both retrospectively and prospectively, in order to
36 improve the quality of medical care of patients and to prevent medical
37 malpractice. The committee shall oversee and coordinate the quality

1 improvement and medical malpractice prevention program and shall insure
2 that information gathered pursuant to the program is used to review and
3 to revise hospital policies and procedures(~~(. At least one member of~~
4 ~~the committee shall be a member of the governing board of the hospital~~
5 ~~who is not otherwise affiliated with the hospital in an employment or~~
6 ~~contractual capacity))~~);

7 (b) A medical staff privileges sanction procedure through which
8 credentials, physical and mental capacity, and competence in delivering
9 health care services are periodically reviewed as part of an evaluation
10 of staff privileges;

11 (c) The periodic review of the credentials, physical and mental
12 capacity, and competence in delivering health care services of all
13 persons who are employed or associated with the hospital;

14 (d) A procedure for the prompt resolution of grievances by patients
15 or their representatives related to accidents, injuries, treatment, and
16 other events that may result in claims of medical malpractice;

17 (e) The maintenance and continuous collection of information
18 concerning the hospital's experience with negative health care outcomes
19 and incidents injurious to patients, patient grievances, professional
20 liability premiums, settlements, awards, costs incurred by the hospital
21 for patient injury prevention, and safety improvement activities;

22 (f) The maintenance of relevant and appropriate information
23 gathered pursuant to (a) through (e) of this subsection concerning
24 individual physicians within the physician's personnel or credential
25 file maintained by the hospital;

26 (g) Education programs dealing with quality improvement, patient
27 safety, injury prevention, staff responsibility to report professional
28 misconduct, the legal aspects of patient care, improved communication
29 with patients, and causes of malpractice claims for staff personnel
30 engaged in patient care activities; and

31 (h) Policies to ensure compliance with the reporting requirements
32 of this section.

33 (2) Any person who, in substantial good faith, provides information
34 to further the purposes of the quality improvement and medical
35 malpractice prevention program or who, in substantial good faith,
36 participates on the quality ((assurance)) improvement committee shall
37 not be subject to an action for civil damages or other relief as a
38 result of such activity.

1 (3) Information and documents, including complaints and incident
2 reports, created specifically for, and collected, and maintained
3 ~~((about health care providers arising out of the matters that are under~~
4 ~~review or have been evaluated))~~ by a ~~((review))~~ quality improvement
5 committee ~~((conducting quality assurance reviews))~~ are not subject to
6 discovery or introduction into evidence in any civil action, and no
7 person who was in attendance at a meeting of such committee or
8 ~~((board))~~ who participated in the creation, collection, or maintenance
9 of information or documents specifically for the committee shall be
10 permitted or required to testify in any civil action as to the content
11 of such proceedings or the documents and information prepared
12 specifically for the committee. This subsection does not preclude:
13 (a) In any civil action, the discovery of the identity of persons
14 involved in the medical care that is the basis of the civil action
15 whose involvement was independent of any quality improvement activity;
16 (b) in any civil action, the testimony of any person concerning the
17 facts which form the basis for the institution of such proceedings of
18 which the person had personal knowledge acquired independently of such
19 proceedings; ~~((b))~~ (c) in any civil action by a health care provider
20 regarding the restriction or revocation of that individual's clinical
21 or staff privileges, introduction into evidence information collected
22 and maintained by quality ~~((assurance))~~ improvement committees
23 regarding such health care provider; ~~((e))~~ (d) in any civil action,
24 disclosure of the fact that staff privileges were terminated or
25 restricted, including the specific restrictions imposed, if any and the
26 reasons for the restrictions; or ~~((d))~~ (e) in any civil action,
27 discovery and introduction into evidence of the patient's medical
28 records required by regulation of the department of health to be made
29 regarding the care and treatment received.

30 (4) Each quality improvement committee shall, on at least a
31 semiannual basis, report to the governing board of the hospital in
32 which the committee is located. The report shall review the quality
33 improvement activities conducted by the committee, and any actions
34 taken as a result of those activities.

35 (5) The department of health shall adopt such rules as are deemed
36 appropriate to effectuate the purposes of this section.

37 ~~((5))~~ (6) The medical disciplinary board or the board of
38 osteopathic medicine and surgery, as appropriate, may review and audit
39 the records of committee decisions in which a physician's privileges

1 are terminated or restricted. Each hospital shall produce and make
2 accessible to the board the appropriate records and otherwise
3 facilitate the review and audit. Information so gained shall not be
4 subject to the discovery process and confidentiality shall be respected
5 as required by subsection (3) of this section. Failure of a hospital
6 to comply with this subsection is punishable by a civil penalty not to
7 exceed two hundred fifty dollars.

8 ~~((6))~~ (7) Violation of this section shall not be considered
9 negligence per se.

10 **Sec. 416.** RCW 70.41.230 and 1991 c 3 s 337 are each amended to
11 read as follows:

12 REQUEST FOR STAFF PRIVILEGES. (1) Prior to granting or renewing
13 clinical privileges or association of any physician or hiring a
14 physician, a hospital or facility approved pursuant to this chapter
15 shall request from the physician and the physician shall provide the
16 following information:

17 (a) The name of any hospital or facility with or at which the
18 physician had or has any association, employment, privileges, or
19 practice;

20 (b) If such association, employment, privilege, or practice was
21 discontinued, the reasons for its discontinuation;

22 (c) Any pending professional medical misconduct proceedings or any
23 pending medical malpractice actions in this state or another state, the
24 substance of the allegations in the proceedings or actions, and any
25 additional information concerning the proceedings or actions as the
26 physician deems appropriate;

27 (d) The substance of the findings in the actions or proceedings and
28 any additional information concerning the actions or proceedings as the
29 physician deems appropriate;

30 (e) A waiver by the physician of any confidentiality provisions
31 concerning the information required to be provided to hospitals
32 pursuant to this subsection; and

33 (f) A verification by the physician that the information provided
34 by the physician is accurate and complete.

35 (2) Prior to granting privileges or association to any physician or
36 hiring a physician, a hospital or facility approved pursuant to this
37 chapter shall request from any hospital with or at which the physician

1 had or has privileges, was associated, or was employed, the following
2 information concerning the physician:

3 (a) Any pending professional medical misconduct proceedings or any
4 pending medical malpractice actions, in this state or another state;

5 (b) Any judgment or settlement of a medical malpractice action and
6 any finding of professional misconduct in this state or another state
7 by a licensing or disciplinary board; and

8 (c) Any information required to be reported by hospitals pursuant
9 to RCW 18.72.265.

10 (3) The medical disciplinary board shall be advised within thirty
11 days of the name of any physician denied staff privileges, association,
12 or employment on the basis of adverse findings under subsection (1) of
13 this section.

14 (4) A hospital or facility that receives a request for information
15 from another hospital or facility pursuant to subsections (1) and (2)
16 of this section shall provide such information concerning the physician
17 in question to the extent such information is known to the hospital or
18 facility receiving such a request, including the reasons for
19 suspension, termination, or curtailment of employment or privileges at
20 the hospital or facility. A hospital, facility, or other person
21 providing such information in good faith is not liable in any civil
22 action for the release of such information.

23 (5) Information and documents, including complaints and incident
24 reports, created specifically for, and collected, and maintained
25 ~~((about health care providers arising out of the matters that are under~~
26 ~~review or have been evaluated))~~ by a ~~((review))~~ quality improvement
27 committee ~~((conducting quality assurance reviews))~~ are not subject to
28 discovery or introduction into evidence in any civil action, and no
29 person who was in attendance at a meeting of such committee or
30 ~~((board))~~ who participated in the creation, collection, or maintenance
31 of information or documents specifically for the committee shall be
32 permitted or required to testify in any civil action as to the content
33 of such proceedings or the documents and information prepared
34 specifically for the committee. This subsection does not preclude:
35 (a) In any civil action, the discovery of the identity of persons
36 involved in the medical care that is the basis of the civil action
37 whose involvement was independent of any quality improvement activity;
38 (b) in any civil action, the testimony of any person concerning the
39 facts which form the basis for the institution of such proceedings of

1 which the person had personal knowledge acquired independently of such
2 proceedings; ~~((b))~~ (c) in any civil action by a health care provider
3 regarding the restriction or revocation of that individual's clinical
4 or staff privileges, introduction into evidence information collected
5 and maintained by quality ~~((assurance))~~ improvement committees
6 regarding such health care provider; ~~((e))~~ (d) in any civil action,
7 disclosure of the fact that staff privileges were terminated or
8 restricted, including the specific restrictions imposed, if any and the
9 reasons for the restrictions; or ~~((d))~~ (e) in any civil action,
10 discovery and introduction into evidence of the patient's medical
11 records required by regulation of the department of health to be made
12 regarding the care and treatment received.

13 (6) Hospitals shall be granted access to information held by the
14 medical disciplinary board and the board of osteopathic medicine and
15 surgery pertinent to decisions of the hospital regarding credentialing
16 and recredentialing of practitioners.

17 (7) Violation of this section shall not be considered negligence
18 per se.

19 NEW SECTION. **Sec. 417.** A new section is added to chapter 43.70
20 RCW to read as follows:

21 COORDINATED QUALITY IMPROVEMENT PROGRAM. (1)(a) Health care
22 institutions and medical facilities, other than hospitals, that are
23 licensed by the department, professional societies or organizations,
24 and certified health plans approved pursuant to section 428 of this act
25 may maintain a coordinated quality improvement program for the
26 improvement of the quality of health care services rendered to patients
27 and the identification and prevention of medical malpractice as set
28 forth in RCW 70.41.200.

29 (b) All such programs shall comply with the requirements of RCW
30 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to
31 reflect the structural organization of the institution, facility,
32 professional societies or organizations, or certified health plan,
33 unless an alternative quality improvement program substantially
34 equivalent to RCW 70.41.200(1)(a) is developed. All such programs,
35 whether complying with the requirement set forth in RCW 70.41.200(1)(a)
36 or in the form of an alternative program, must be approved by the
37 department before the discovery limitations provided in subsections (3)
38 and (4) of this section shall apply. In reviewing plans submitted by

1 licensed entities that are associated with physicians' offices, the
2 department shall ensure that the discovery limitations of this section
3 are applied only to information and documents related specifically to
4 quality improvement activities undertaken by the licensed entity.

5 (2) Health care provider groups of ten or more providers may
6 maintain a coordinated quality improvement program for the improvement
7 of the quality of health care services rendered to patients and the
8 identification and prevention of medical malpractice as set forth in
9 RCW 70.41.200. All such programs shall comply with the requirements of
10 RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to
11 reflect the structural organization of the health care provider group.
12 All such programs must be approved by the department before the
13 discovery limitations provided in subsections (3) and (4) of this
14 section shall apply.

15 (3) Any person who, in substantial good faith, provides information
16 to further the purposes of the quality improvement and medical
17 malpractice prevention program or who, in substantial good faith,
18 participates on the quality improvement committee shall not be subject
19 to an action for civil damages or other relief as a result of such
20 activity.

21 (4) Information and documents, including complaints and incident
22 reports, created specifically for, and collected, and maintained by a
23 quality improvement committee are not subject to discovery or
24 introduction into evidence in any civil action, and no person who was
25 in attendance at a meeting of such committee or who participated in the
26 creation, collection, or maintenance of information or documents
27 specifically for the committee shall be permitted or required to
28 testify in any civil action as to the content of such proceedings or
29 the documents and information prepared specifically for the committee.
30 This subsection does not preclude: (a) In any civil action, the
31 discovery of the identity of persons involved in the medical care that
32 is the basis of the civil action whose involvement was independent of
33 any quality improvement activity; (b) in any civil action, the
34 testimony of any person concerning the facts that form the basis for
35 the institution of such proceedings of which the person had personal
36 knowledge acquired independently of such proceedings; (c) in any civil
37 action by a health care provider regarding the restriction or
38 revocation of that individual's clinical or staff privileges,
39 introduction into evidence information collected and maintained by

1 quality improvement committees regarding such health care provider; (d)
2 in any civil action, disclosure of the fact that staff privileges were
3 terminated or restricted, including the specific restrictions imposed,
4 if any and the reasons for the restrictions; or (e) in any civil
5 action, discovery and introduction into evidence of the patient's
6 medical records required by rule of the department of health to be made
7 regarding the care and treatment received.

8 (5) The department of health shall adopt rules as are necessary to
9 implement this section.

10 NEW SECTION. **Sec. 418.** MEDICAL MALPRACTICE REVIEW. (1) The
11 administrator for the courts shall coordinate a collaborative effort to
12 develop a voluntary system for review of medical malpractice claims by
13 health services experts prior to the filing of a cause of action under
14 chapter 7.70 RCW.

15 (2) The system shall have at least the following components:

16 (a) Review would be initiated, by agreement of the injured claimant
17 and the health care provider, at the point at which a medical
18 malpractice claim is submitted to a malpractice insurer or a self-
19 insured health care provider.

20 (b) By agreement of the parties, an expert would be chosen from a
21 pool of health services experts who have agreed to review claims on a
22 voluntary basis.

23 (c) The mutually agreed upon expert would conduct an impartial
24 review of the claim and provide his or her opinion to the parties.

25 (d) A pool of available experts would be established and maintained
26 for each category of health care practitioner by the corresponding
27 practitioner association, such as the Washington state medical
28 association and the Washington state nurses association.

29 (3) The administrator for the courts shall seek to involve at least
30 the following organizations in a collaborative effort to develop the
31 informal review system described in subsection (2) of this section:

32 (a) The Washington defense trial lawyers association;

33 (b) The Washington state trial lawyers association;

34 (c) The Washington state medical association;

35 (d) The Washington state nurses association and other employee
36 organizations representing nurses;

37 (e) The Washington state hospital association;

- 1 (f) The Washington state physicians insurance exchange and
2 association;
- 3 (g) The Washington casualty company;
- 4 (h) The doctor's agency;
- 5 (i) Group health cooperative of Puget Sound;
- 6 (j) The University of Washington;
- 7 (k) Washington osteopathic medical association;
- 8 (l) Washington state chiropractic association;
- 9 (m) Washington association of naturopathic physicians; and
10 (n) The department of health.

11 (4) On or before January 1, 1994, the administrator for the courts
12 shall provide a report on the status of the development of the system
13 described in this section to the governor and the appropriate
14 committees of the senate and the house of representatives.

15 NEW SECTION. **Sec. 419.** A new section is added to chapter 7.70 RCW
16 to read as follows:

17 MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. (1) All
18 causes of action, whether based in tort, contract, or otherwise, for
19 damages arising from injury occurring as a result of health care
20 provided after the effective date of this section shall be subject to
21 mandatory mediation prior to trial.

22 (2) The supreme court shall by rule adopt procedures to implement
23 mandatory mediation of actions under this chapter. The rules shall
24 address, at a minimum:

25 (a) Procedures for the appointment of, and qualifications of,
26 mediators. A mediator shall have experience or expertise related to
27 actions arising from injury occurring as a result of health care, and
28 be a member of the state bar association who has been admitted to the
29 bar for a minimum of five years or who is a retired judge. The parties
30 may stipulate to a nonlawyer mediator. The court may prescribe
31 additional qualifications of mediators;

32 (b) Appropriate limits on the amount or manner of compensation of
33 mediators;

34 (c) The number of days following the filing of a claim under this
35 chapter within which a mediator must be selected;

36 (d) The method by which a mediator is selected. The rule shall
37 provide for designation of a mediator by the superior court if the
38 parties are unable to agree upon a mediator;

1 (e) The number of days following the selection of a mediator within
2 which a mediation conference must be held;

3 (f) A means by which mediation of an action under this chapter may
4 be waived by a mediator who has determined that the claim is not
5 appropriate for mediation; and

6 (g) Any other matters deemed necessary by the court.

7 (3) Mediators shall not impose discovery schedules upon the
8 parties.

9 NEW SECTION. **Sec. 420.** A new section is added to chapter 7.70 RCW
10 to read as follows:

11 MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE. The making of a
12 written, good faith request for mediation of a dispute related to
13 damages for injury occurring as a result of health care provided prior
14 to filing a cause of action under this chapter shall toll the statute
15 of limitations provided in RCW 4.16.350.

16 NEW SECTION. **Sec. 421.** A new section is added to chapter 7.70 RCW
17 to read as follows:

18 MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS. Section 419
19 of this act may not be construed to abridge the right to trial by jury
20 following an unsuccessful attempt at mediation.

21 **Sec. 422.** RCW 5.60.070 and 1991 c 321 s 1 are each amended to read
22 as follows:

23 MEDIATION--COMMUNICATIONS PRIVILEGED. (1) If there is a court
24 order to mediate (~~(or)~~), a written agreement between the parties to
25 mediate, or if mediation is mandated under section 419 of this act,
26 then any communication made or materials submitted in, or in connection
27 with, the mediation proceeding, whether made or submitted to or by the
28 mediator, a mediation organization, a party, or any person present, are
29 privileged and confidential and are not subject to disclosure in any
30 judicial or administrative proceeding except:

31 (a) When all parties to the mediation agree, in writing, to
32 disclosure;

33 (b) When the written materials or tangible evidence are otherwise
34 subject to discovery, and were not prepared specifically for use in and
35 actually used in the mediation proceeding;

36 (c) When a written agreement to mediate permits disclosure;

1 (d) When disclosure is mandated by statute;

2 (e) When the written materials consist of a written settlement
3 agreement or other agreement signed by the parties resulting from a
4 mediation proceeding;

5 (f) When those communications or written materials pertain solely
6 to administrative matters incidental to the mediation proceeding,
7 including the agreement to mediate; or

8 (g) In a subsequent action between the mediator and a party to the
9 mediation arising out of the mediation.

10 (2) When there is a court order ~~((or))~~, a written agreement to
11 mediate, or when mediation is mandated under section 419 of this act,
12 as described in subsection (1) of this section, the mediator or a
13 representative of a mediation organization shall not testify in any
14 judicial or administrative proceeding unless:

15 (a) All parties to the mediation and the mediator agree in writing;
16 or

17 (b) In an action described in subsection (1)(g) of this section.

18 **NEW SECTION. Sec. 423.** A new section is added to chapter 7.70 RCW
19 to read as follows:

20 **MANDATORY MEDIATION OF HEALTH CARE MALPRACTICE CLAIMS.** A cause of
21 action that has been mediated as provided in section 419 of this act
22 shall be exempt from any superior court civil rules mandating
23 arbitration of civil actions or participation in settlement conferences
24 prior to trial.

25 **Sec. 424.** RCW 4.22.070 and 1986 c 305 s 401 are each amended to
26 read as follows:

27 **PERCENTAGE OF FAULT--JOINT AND SEVERAL LIABILITY.** (1) Except as
28 provided in subsection (4) of this section, in all actions involving
29 fault of more than one entity, the trier of fact shall determine the
30 percentage of the total fault which is attributable to every entity
31 which caused the claimant's damages, including the claimant or person
32 suffering personal injury or incurring property damage, defendants,
33 third-party defendants, entities released by the claimant, entities
34 immune from liability to the claimant and entities with any other
35 individual defense against the claimant. Judgment shall be entered
36 against each defendant except those who have been released by the
37 claimant or are immune from liability to the claimant or have prevailed

1 on any other individual defense against the claimant in an amount which
2 represents that party's proportionate share of the claimant's total
3 damages. The liability of each defendant shall be several only and
4 shall not be joint except:

5 (a) A party shall be responsible for the fault of another person or
6 for payment of the proportionate share of another party where both were
7 acting in concert or when a person was acting as an agent or servant of
8 the party.

9 (b) If the trier of fact determines that the claimant or party
10 suffering bodily injury or incurring property damages was not at fault,
11 the defendants against whom judgment is entered shall be jointly and
12 severally liable for the sum of their proportionate shares of the
13 claimants total damages.

14 (2) If a defendant is jointly and severally liable under one of the
15 exceptions listed in subsection((s)) (1)(a) or (1)(b) or (4) (a) or (b)
16 of this section, such defendant's rights to contribution against
17 another jointly and severally liable defendant, and the effect of
18 settlement by either such defendant, shall be determined under RCW
19 4.22.040, 4.22.050, and 4.22.060.

20 (3)(a) Nothing in this section affects any cause of action relating
21 to hazardous wastes or substances or solid waste disposal sites.

22 (b) Nothing in this section shall affect a cause of action arising
23 from the tortious interference with contracts or business relations.

24 (c) Nothing in this section shall affect any cause of action
25 arising from the manufacture or marketing of a fungible product in a
26 generic form which contains no clearly identifiable shape, color, or
27 marking.

28 (4) In all actions governed by chapter 7.70 RCW involving fault of
29 more than one entity, the trier of fact shall determine the percentage
30 of the total fault that is attributable to every entity that caused the
31 claimant's damages, including the claimant or person suffering personal
32 injury or incurring property damage, defendants, third-party
33 defendants, entities released by the claimant, entities immune from
34 liability to the claimant, and entities with any other individual
35 defense against the claimant. Judgment shall be entered against each
36 defendant except those who have been released by the claimant or are
37 immune from liability to the claimant or have prevailed on any other
38 individual defense against the claimant in an amount that represents
39 that party's proportionate share of the claimant's total damages. The

1 total damages shall first be reduced by any amount paid to the claimant
2 by a released entity. The liability of each defendant shall be several
3 only and shall not be joint except:

4 (a) A party shall be responsible for the fault of another person or
5 for payment of the proportionate share of another party where both were
6 acting in concert or when a person was acting as an agent or servant of
7 the party.

8 (b) If the trier of fact determines that the claimant or party
9 suffering bodily injury or incurring property damages was not at fault,
10 the defendants against whom judgment is entered shall be jointly and
11 severally liable for the sum of their proportionate shares of the
12 claimant's total damages.

13 (c) A defendant against whom judgment has been entered shall be
14 responsible to the claimant for any fault of an entity released by the
15 claimant. The total damages shall first be reduced by any amount paid
16 to the claimant by a released entity, and, then, where some fault has
17 been attributed to the claimant, by the claimant's proportionate share
18 of his or her total damages.

19 **D. HEALTH INSURANCE PURCHASING COOPERATIVES**

20 NEW SECTION. Sec. 425. HEALTH INSURANCE PURCHASING COOPERATIVES--
21 DESIGNATION OF REGIONS BY COMMISSION, INFORMATION SYSTEMS, MINIMUM
22 STANDARDS, AND RULES. (1) The commission shall designate four
23 geographic regions within the state in which health insurance
24 purchasing cooperatives may operate, based upon population, assuming
25 that each cooperative must serve no less than one hundred fifty
26 thousand persons; geographic factors; market conditions; and other
27 factors deemed appropriate by the commission. The commission shall
28 designate one health insurance purchasing cooperative per region.

29 (2) In coordination with the commission and consistent with the
30 provisions of chapter 70.170 RCW, the department of health shall
31 establish an information clearinghouse for the collection and
32 dissemination of information necessary for the efficient operation of
33 cooperatives, including the establishment of a risk profile information
34 system related to certified health plan enrollees that would permit the
35 equitable distribution of losses among plans in accordance with section
36 406(7) of this act.

37 (3) Every health insurance purchasing cooperative shall:

1 (a) Admit all individuals, employers, or other groups wishing to
2 participate in the cooperative;

3 (b) Make available for purchase by cooperative members every health
4 care program offered by every certified health plan operating within
5 the cooperative's region;

6 (c) Be operated as a member-governed and owned, nonprofit
7 cooperative in which no certified health plan, health maintenance
8 organization, health care service contractor, independent practice
9 association, independent physician organization, or any individual with
10 a pecuniary interest in any such organization, shall have any pecuniary
11 interest in or management control of the cooperative;

12 (d) Provide for centralized enrollment and premium collection and
13 distribution among certified health plans; and

14 (e) Serve as an ombudsman for its members to resolve inquiries,
15 complaints, or other concerns with certified health plans.

16 (4) Every health insurance purchasing cooperative shall assist
17 members in selecting certified health plans and for this purpose may
18 devise a rating system or similar system to judge the quality and cost-
19 effectiveness of certified health plans consistent with guidelines
20 established by the commission. For this purpose, each cooperative and
21 directors, officers, and other employees of the cooperative are immune
22 from liability in any civil action or suit arising from the publication
23 of any report, brochure, or guide, or dissemination of information
24 related to the services, quality, price, or cost-effectiveness of
25 certified plans unless actual malice, fraud, or bad faith is shown.
26 Such immunity is in addition to any common law or statutory privilege
27 or immunity enjoyed by such person, and nothing in this section is
28 intended to abrogate or modify in any way such common law or statutory
29 privilege or immunity.

30 (5) Every health insurance purchasing cooperative shall bear the
31 full cost of its operations, including the costs of participating in
32 the information clearinghouse, through assessments upon its members.
33 Such assessments shall be billed and accounted for separately from
34 premiums collected and distributed for the purchase of the uniform
35 benefits package or any other supplemental insurance or health services
36 program.

37 (6) No health insurance purchasing cooperative may bear any
38 financial risk for the delivery of uniform benefits package services,
39 or for any other supplemental insurance or health services program.

1 (7) No health insurance purchasing cooperative may directly broker,
2 sell, contract for, or provide any insurance or health services
3 program. However, nothing contained in this section shall be deemed to
4 prohibit the use or employment of insurance agents or brokers by the
5 cooperative for other purposes or to prohibit the facilitation of the
6 sale and purchase by members of supplemental insurance or health
7 services programs.

8 (8) The commission may adopt rules necessary for the implementation
9 of this section including rules governing charter and bylaw provisions
10 of cooperatives and may adopt rules prohibiting or permitting other
11 activities by cooperatives.

12 (9) The commission shall consider ways in which cooperatives can
13 develop, encourage, and provide incentives for employee wellness
14 programs.

15 NEW SECTION. **Sec. 426.** LICENSING AND REGULATION OF HEALTH
16 INSURANCE PURCHASING COOPERATIVES BY THE INSURANCE COMMISSIONER. (1)
17 No person may establish or operate a health insurance purchasing
18 cooperative without having first obtained a certificate of authority
19 from the insurance commissioner.

20 (2) Every proposed cooperative shall furnish notice to the
21 insurance commissioner that shall:

22 (a) Identify the principal name and address of the cooperative;

23 (b) Furnish the names and addresses of the initial officers of the
24 cooperative;

25 (c) Include copies of letters of agreement for participation in the
26 cooperative including minimum term of participation;

27 (d) Furnish copies of its proposed articles and bylaws; and

28 (e) Provide other information as prescribed by the insurance
29 commissioner in consultation with the health services commission to
30 verify that the cooperative is qualified and is managed by competent
31 and trustworthy individuals.

32 (3)(a) The commissioner shall approve applications for certificates
33 in accordance with the order received.

34 (b) The commissioner shall establish by rule a fee to be paid by
35 cooperatives in an amount necessary to review and approve applications
36 for a certificate of authority. Such fee shall accompany the
37 application and no certificate may be issued until such fee is paid.

1 Fees collected for such purpose shall be deposited in the insurance
2 commissioner's regulatory account in the state treasury.

3 (4) All funds representing premiums or return premiums received by
4 a cooperative in its fiduciary capacity shall be accounted for and
5 maintained in a separate account from all other funds. Each willful
6 violation of this section constitutes a misdemeanor.

7 (5) Every cooperative shall keep at its principal address, a record
8 of all transactions it has consummated on behalf of its members with
9 certified health plans. All such records shall be kept available and
10 open to the inspection of the insurance commissioner at any business
11 time during a five-year period immediately after the date of completion
12 of the transaction.

13 **E. CERTIFIED HEALTH PLANS**

14 NEW SECTION. **Sec. 427.** CERTIFIED HEALTH PLANS--CERTIFICATION
15 REQUIRED--PENALTY. (1) On and after July 1, 1995, no person or entity
16 in this state shall provide the uniform benefits package and
17 supplemental benefits as defined in section 402 of this act without
18 being certified as a certified health plan by the insurance
19 commissioner.

20 (2) On and after July 1, 1995, no certified health plan may offer
21 less than the uniform benefits package to residents of this state and
22 no registered employer health plan may provide less than the uniform
23 benefits package to its employees and their dependents.

24 NEW SECTION. **Sec. 428.** HEALTH PLAN CERTIFICATION STANDARDS. A
25 certified health plan shall:

26 (1) Provide the benefits included in the uniform benefits package
27 to enrolled Washington residents for a prepaid per capita community-
28 rated premium not to exceed the maximum premium established by the
29 commission and provide such benefits through managed care in accordance
30 with rules adopted by the commission;

31 (2) Offer supplemental benefits to enrolled Washington residents
32 for a prepaid per capita community-rated premium and provide such
33 benefits through managed care in accordance with rules adopted by the
34 commission;

35 (3) Accept for enrollment any state resident within the plan's
36 service area and provide or assure the provision of all services within

1 the uniform benefits package and offer supplemental benefits regardless
2 of age, sex, family structure, ethnicity, race, health condition,
3 geographic location, employment status, socioeconomic status, other
4 condition or situation, or the provisions of RCW 49.60.174(2). The
5 insurance commissioner may grant a temporary exemption from this
6 subsection, if, upon application by a certified health plan, the
7 commissioner finds that the clinical, financial, or administrative
8 capacity to serve existing enrollees will be impaired if a certified
9 health plan is required to continue enrollment of additional eligible
10 individuals;

11 (4) If the plan provides benefits through contracts with, ownership
12 of, or management of health care facilities and contracts with or
13 employs health care providers, demonstrate to the satisfaction of the
14 insurance commissioner in consultation with the department of health
15 and the commission that its facilities and personnel are adequate to
16 provide the benefits prescribed in the uniform benefits package and
17 offer supplemental benefits to enrolled Washington residents, and that
18 it is financially capable of providing such residents with, or has made
19 adequate contractual arrangements with health care providers and
20 facilities to provide enrollees with such benefits;

21 (5) Comply with portability of benefits requirements prescribed by
22 the commission;

23 (6) Comply with administrative rules prescribed by the commission,
24 the insurance commissioner, and other state agencies governing
25 certified health plans;

26 (7) Provide all enrollees with instruction and informational
27 materials to increase individual and family awareness of injury and
28 illness prevention; encourage assumption of personal responsibility for
29 protecting personal health; and stimulate discussion about the use and
30 limits of medical care in improving the health of individuals and
31 communities;

32 (8) Disclose to enrollees the charity care requirements under
33 chapter 70.170 RCW;

34 (9) Include in all of its contracts with health care providers and
35 health care facilities a provision prohibiting such providers and
36 facilities from billing enrollees for any amounts in excess of
37 applicable enrollee point of service cost-sharing obligations for
38 services included in the uniform benefits package and supplemental
39 benefits;

1 (10) Include in all of its contracts issued for uniform benefits
2 package and supplemental benefits coverage a subrogation provision that
3 allows the certified health plan to recover the costs of uniform
4 benefits package and supplemental benefits services incurred to care
5 for an enrollee injured by a negligent third party. The costs
6 recovered shall be limited to:

7 (a) If the certified health plan has not intervened in the action
8 by an injured enrollee against a negligent third party, then the amount
9 of costs the certified health plan can recover shall be limited to the
10 excess remaining after the enrollee has been fully compensated for his
11 or her loss minus a proportionate share of the enrollee's costs and
12 fees in bringing the action. The proportionate share shall be
13 determined by:

14 (i) The fees and costs approved by the court in which the action
15 was initiated; or

16 (ii) The written agreement between the attorney and client that
17 established fees and costs when fees and costs are not addressed by the
18 court.

19 When fees and costs have been approved by a court, after notice to
20 the certified health plan, the certified health plan shall have the
21 right to be heard on the matter of attorneys' fees and costs or its
22 proportionate share;

23 (b) If the certified health plan has intervened in the action by an
24 injured enrollee against a negligent third party, then the amount of
25 costs the certified health plan can recover shall be the excess
26 remaining after the enrollee has been fully compensated for his or her
27 loss or the amount of the plan's incurred costs, whichever is less;

28 (11) Establish and maintain a grievance procedure approved by the
29 commissioner, to provide a reasonable and effective resolution of
30 complaints initiated by enrollees concerning any matter relating to the
31 provision of benefits under the uniform benefits package and
32 supplemental benefits, access to health care services, and quality of
33 services. Each certified health plan shall respond to complaints filed
34 with the insurance commissioner within fifteen working days. The
35 insurance commissioner in consultation with the commission shall
36 establish standards for resolution of grievances;

37 (12) Comply with the provisions of chapter 48.30 RCW prohibiting
38 unfair and deceptive acts and practices to the extent such provisions
39 are not specifically modified or superseded by the provisions of

1 chapter . . . , Laws of 1993 (this act) and be prohibited from offering
2 or supplying incentives that would have the effect of avoiding the
3 requirements of subsection (3) of this section;

4 (13) Have culturally sensitive health promotion programs that
5 include approaches that are specifically effective for persons of color
6 and accommodating to different cultural value systems, gender, and age;

7 (14) Permit every category of health care provider to provide
8 health services or care for conditions included in the uniform benefits
9 package to the extent that:

10 (a) The provision of such health services or care is within the
11 health care providers' permitted scope of practice; and

12 (b) The providers agree to abide by standards related to:

13 (i) Provision, utilization review, and cost containment of health
14 services;

15 (ii) Management and administrative procedures; and

16 (iii) Provision of cost-effective and clinically efficacious health
17 services;

18 (15) Establish the geographic boundaries in which they will
19 obligate themselves to deliver the services required under the uniform
20 benefits package and include such information in their application for
21 certification, but the commissioner shall review such boundaries and
22 may disapprove, in conformance with guidelines adopted by the
23 commission, those that have been clearly drawn to be exclusionary
24 within a health care catchment area;

25 (16) Annually report the names and addresses of all officers,
26 directors, or trustees of the certified health plan during the
27 preceding year, and the amount of wages, expense reimbursements, or
28 other payments to such individuals;

29 (17) Annually report the number of residents enrolled and
30 terminated during the previous year. Additional information regarding
31 the enrollment and termination pattern for a certified health plan may
32 be required by the commissioner to determine compliance with the open
33 enrollment and free access requirements of chapter..., Laws of 1993
34 (this act); and

35 (18) Disclose any financial interests held by officers and
36 directors in any facilities associated with or operated by the
37 certified health plan.

1 NEW SECTION. **Sec. 429.** LIMITED CERTIFIED HEALTH PLAN FOR DENTAL
2 SERVICES. (1) For the purposes of this section "limited certified
3 dental plan" or "dental plan" means a limited health service contractor
4 governed by RCW 48.44.035 offering dental care services only and that
5 complies with all certified health plan requirements for managed care,
6 community rating, portability, and nondiscrimination as provided in
7 section 428 of this act.

8 (2) A dental plan may provide coverage for dental services directly
9 to individuals or to employers for the benefit of employees. If an
10 individual or an employer purchases dental care services from a dental
11 plan, the certified health plan covering the individual or the
12 employees need not provide dental services required under the uniform
13 benefits package. A certified health plan may subcontract with a
14 dental plan to provide the dental benefits required under the uniform
15 benefits package.

16 NEW SECTION. **Sec. 430.** REGISTERED EMPLOYER HEALTH PLANS.
17 Consistent with the provisions of section 464 of this act, a registered
18 employer health plan shall:

19 (1) Register with the insurance commissioner by filing its plan of
20 management and operation including but not limited to information
21 required by the commissioner sufficient for a determination by the
22 commissioner that such plan meets the requirements of this section and
23 any rules adopted by the health services commission and the insurance
24 commissioner pertaining to such plans.

25 (2) Provide the benefits included in the uniform benefits package
26 to employees and their dependents for a prepaid, community-rated
27 premium not to exceed the maximum premium established by the commission
28 and provide such benefits through managed care in accordance with rules
29 adopted by the commission.

30 (3) Offer supplemental benefits to employees and their dependents
31 for a prepaid, community-rated premium and provide such benefits
32 through managed care in accordance with rules adopted by the
33 commission. Benefits offered by such plan need not comply with the
34 provisions of sections 452 and 453 of this act.

35 (4) Provide or assure the provision of all services within the
36 uniform benefits package and offer supplemental benefits regardless of
37 age, sex, family structure, ethnicity, race, health condition,

1 socioeconomic status, or other condition or situation, or the
2 provisions of RCW 49.60.174(2).

3 (5) If the plan provides benefits through contracts with, ownership
4 of, or management of health care facilities and contracts with or
5 employs health care providers, demonstrate to the satisfaction of the
6 insurance commissioner in consultation with the department of health
7 and the commission that its facilities and personnel are adequate to
8 provide the uniform benefits package and any supplemental benefits or
9 has made adequate contractual arrangements with health care providers
10 and facilities to provide employees and their dependents with such
11 benefits.

12 (6) Comply with portability of benefits requirements prescribed by
13 the commission for registered employer health plans.

14 (7) Comply with administrative rules prescribed by the commission,
15 the insurance commissioner, and other state agencies governing
16 registered employer health plans.

17 (8) Provide all employees and their dependents enrolled in the plan
18 with instruction and informational materials to increase individual and
19 family awareness of injury and illness prevention; encourage assumption
20 of personal responsibility for protecting personal health; and
21 stimulate discussion about the use and limits of medical care in
22 improving the health of individuals and communities.

23 (9) Include in all of its contracts with health care providers and
24 health care facilities a provision prohibiting such providers and
25 facilities from billing employees and their dependents enrolled in the
26 plan for any amounts in excess of applicable enrollee point of service,
27 cost-sharing obligations for services included in the uniform benefits
28 package and supplemental benefits.

29 (10) Include in all of its contracts issued for uniform benefits
30 package and supplemental benefits coverage a subrogation provision that
31 allows the plan to recover the costs of uniform benefits package and
32 supplemental benefit services incurred to care for a plan enrollee
33 injured by a negligent third party. The costs recovered shall be
34 limited to:

35 (a) If the plan has not intervened in the action by an injured plan
36 enrollee against a negligent third party, then the amount of costs the
37 plan can recover shall be limited to the excess remaining after the
38 plan enrollee has been fully compensated for his or her loss minus a

1 proportionate share of the enrollee's costs and fees in bringing the
2 action. The proportionate share shall be determined by:

3 (i) The fees and costs approved by the court in which the action
4 was initiated; or

5 (ii) The written agreement between the attorney and client that
6 established fees and costs when fees and costs are not addressed by the
7 court.

8 When fees and costs have been approved by a court, after notice to
9 the plan, the plan shall have the right to be heard on the matter of
10 attorneys' fees and costs or its proportionate share;

11 (b) If the plan has intervened in the action by an injured enrollee
12 against a negligent third party, then the amount of costs the plan can
13 recover shall be the excess remaining after the enrollee has been fully
14 compensated for his or her loss or the amount of the plan's incurred
15 costs, whichever is less.

16 (11) Establish and maintain a grievance procedure approved by the
17 insurance commissioner, to provide a reasonable and effective
18 resolution of complaints initiated by plan enrollees concerning any
19 matter relating to the provision of benefits under the uniform benefits
20 package and supplemental benefits, access to health care services, and
21 quality of services. Each plan shall respond to complaints filed with
22 the insurance commissioner within fifteen working days. The insurance
23 commissioner in consultation with the commission shall establish
24 standards for resolution of grievances by enrollees of registered
25 employer health plans.

26 (12) Have culturally sensitive health promotion programs that
27 include approaches that are specifically effective for persons of color
28 and accommodating to different cultural value systems, gender, and age.

29 (13) Permit every category of health care provider to provide
30 health services or care for conditions included in the uniform benefits
31 package to the extent that:

32 (a) The provision of such health services or care is within the
33 health care providers' permitted scope of practice; and

34 (b) The providers agree to abide by standards related to:

35 (i) Provision, utilization review, and cost containment of health
36 services;

37 (ii) Management and administrative procedures; and

38 (iii) Provision of cost-effective and clinically efficacious health
39 services.

1 (14) Pay to the state treasurer a tax equivalent to the tax applied
2 to taxpayers under section 301 of this act in accordance with rules
3 adopted by the department of revenue.

4 (15) File their uniform benefits package and supplemental benefits
5 with the insurance commissioner who may disapprove and order a
6 modification of such package or benefits if such package or benefits
7 fail to meet any standards or rules adopted by the commission
8 pertaining to maximum premiums, enrollee financial participation, point
9 of service cost-sharing, benefit design, or health service delivery.

10 (16) Comply with and shall be subject to sections 431, 447, and 448
11 of this act.

12 (17) Pay an annual fee to the insurance commissioner's office in an
13 amount established by rule of the commissioner necessary for the
14 performance of the commissioner's responsibilities under this section
15 consistent with and subject to the collection, depositing, and spending
16 provisions applicable to fees collected pursuant to RCW 48.02.190.

17 (18) File an annual report with the commissioner containing such
18 information as the commissioner may require to determine compliance
19 with this section.

20 (19) In addition to any other penalties prescribed by law, be
21 subject to the penalties contained in section 432 of this act for
22 violations of this section.

23 NEW SECTION. **Sec. 431.** CONTRACTS BETWEEN CERTIFIED HEALTH PLANS
24 AND HEALTH CARE PROVIDERS. (1) Balancing the need for health care
25 reform and the need to protect health care providers, as a class and as
26 individual providers, from improper exclusion presents a problem that
27 can be satisfied with the creation of a process to ensure fair
28 consideration of the inclusion of health care providers in managed care
29 systems operated by certified health plans. It is therefore the intent
30 of the legislature that the health services commission in developing
31 rules in accordance with this section and the attorney general in
32 monitoring the level of competition in the various geographic markets,
33 balance the need for cost-effective and quality delivery of health
34 services with the need for inclusion of both individual health care
35 providers and categories of health care providers in managed care
36 programs developed by certified health plans.

37 (2) All licensed health care providers licensed by the state,
38 irrespective of the type or kind of practice, should be afforded the

1 opportunity for inclusion in certified health plans consistent with the
2 goals of health care reform.

3 The health services commission shall adopt rules requiring
4 certified health plans to publish general criteria for the plan's
5 selection or termination of health care providers. Such rules shall
6 not require the disclosure of criteria deemed by the plan to be of a
7 proprietary or competitive nature that would hurt the plan's ability to
8 compete or to manage health services. Disclosure of criteria is
9 proprietary or anticompetitive if revealing the criteria would have the
10 tendency to cause health care providers to alter their practice pattern
11 in a manner that would harm efforts to contain health care costs and is
12 proprietary if revealing the criteria would cause the plan's
13 competitors to obtain valuable business information.

14 If a certified health plan uses unpublished criteria to judge the
15 quality and cost-effectiveness of a health care provider's practice
16 under any specific program within the plan, the plan may not reject or
17 terminate the provider participating in that program based upon such
18 criteria until the provider has been informed of the criteria that his
19 or her practice fails to meet and is given a reasonable opportunity to
20 conform to such criteria.

21 (3)(a) Whenever a determination is made under (b) of this
22 subsection that a plan's share of the market reaches a point where the
23 plan's exclusion of health care providers from a program of the plan
24 would result in the substantial inability of providers to continue
25 their practice thereby unreasonably restricting consumer access to
26 needed health services, the certified health plan must allow all
27 providers within the affected market to participate in the programs of
28 the certified health plan. All such providers must meet the published
29 criteria and requirements of the programs.

30 (b) The attorney general with the assistance of the insurance
31 commissioner shall periodically analyze the market power of certified
32 health plans to determine when the market share of any program of a
33 certified health plan reaches a point where the plan's exclusion of
34 health service providers from a program of the plan would result in the
35 substantial inability of providers to continue their practice thereby
36 unreasonably restricting consumer access to needed health services. In
37 analyzing the market power of a certified health plan, the attorney
38 general shall consider:

1 (i) The ease with which providers may obtain contracts with other
2 plans;

3 (ii) The amount of the private pay and government employer business
4 that is controlled by the certified health plan taking into account the
5 selling of its provider network to self-insured employer plans;

6 (iii) The difficulty in establishing new competing plans in the
7 relevant geographic market; and

8 (iv) The sufficiency of the number or type of providers under
9 contract with the plan available to meet the needs of plan enrollees.

10 Notwithstanding the provisions of this subsection, if the certified
11 health plan demonstrates to the satisfaction of the attorney general
12 and the health services commission that health service utilization data
13 and similar information shows that the inclusion of additional health
14 service providers would substantially lessen the plan's ability to
15 control health care costs and that the plan's procedures for selection
16 of providers are not improperly exclusive of providers, the plan need
17 not include additional providers within the plan's program.

18 (4) The health services commission shall adopt rules for the
19 resolution of disputes between providers and certified health plans
20 including disputes regarding the decision of a plan not to include the
21 services of a provider.

22 (5) Nothing contained in this section shall be construed to require
23 a plan to allow or continue the participation of a provider if the plan
24 is a federally qualified health maintenance organization and the
25 participation of the provider or providers would prevent the health
26 maintenance organization from operating as a health maintenance
27 organization in accordance with 42 U.S.C. Sec. 300e.

28 NEW SECTION. **Sec. 432.** CERTIFIED HEALTH PLANS--REGISTRATION
29 REQUIRED--PENALTY. (1) No person or entity in this state may, by mail
30 or otherwise, act or hold himself or herself out to be a certified
31 health plan as defined by section 402 of this act without being
32 registered as a certified health plan with the insurance commissioner.

33 (2) Anyone violating subsection (1) of this section is liable for
34 a fine not to exceed ten thousand dollars and imprisonment not to
35 exceed six months for each instance of such violation.

36 NEW SECTION. **Sec. 433.** ELIGIBILITY REQUIREMENTS FOR CERTIFICATE
37 OF REGISTRATION--APPLICATION REQUIREMENTS. Any corporation,

1 cooperative group, partnership, association, or groups of health
2 professionals licensed by the state of Washington, public hospital
3 district, or public institutions of higher education are entitled to a
4 certificate from the insurance commissioner as a certified health plan
5 if it:

6 (1) Submits an application for certification as a certified health
7 plan, which shall be verified by an officer or authorized
8 representative of the applicant, being in a form as the insurance
9 commissioner prescribes in consultation with the health services
10 commission;

11 (2) Meets the minimum net worth requirements set forth in section
12 438 of this act and the funding reserve requirements set forth in
13 section 439 of this act;

14 (3) A certified health plan may establish the geographic boundaries
15 in which they will obligate themselves to deliver the services required
16 under the uniform benefits package and include such information in
17 their application for certification, but the commissioner shall review
18 such boundaries and may disapprove, in conformance to guidelines
19 adopted by the commission, those which have been clearly drawn to be
20 exclusionary within a health care catchment area.

21 NEW SECTION. **Sec. 434.** ISSUANCE OF CERTIFICATE--GROUNDS FOR
22 REFUSAL. The commissioner shall issue a certificate as a certified
23 health plan to an applicant within one hundred twenty days of such
24 filing unless the commissioner notifies the applicant within such time
25 that such application is not complete and the reasons therefor; or that
26 the commissioner is not satisfied that:

27 (1) The basic organization document of the applicant permits the
28 applicant to conduct business as a certified health plan;

29 (2) The applicant has demonstrated the intent and ability to assure
30 that the health services will be provided in a manner to assure both
31 their availability and accessibility;

32 (3) The organization is financially responsible and may be
33 reasonably expected to meet its obligations to its enrolled
34 participants. In making this determination, the commissioner shall
35 consider among other relevant factors:

36 (a) Any agreements with a casualty insurer, a government agency, or
37 any other organization paying or insuring payment for health care
38 services;

1 (b) Any agreements with providers for the provision of health care
2 services; and

3 (c) Any arrangements for liability and malpractice insurance
4 coverage.

5 (4) The procedures for offering health care services are reasonable
6 and equitable; and

7 (5) Procedures have been established to:

8 (a) Monitor the quality of care provided by the certified health
9 plan including standards and guidelines provided by the health services
10 commission and other appropriate state agencies;

11 (b) Operate internal peer review mechanisms; and

12 (c) Resolve complaints and grievances in accordance with section
13 443 of this act and rules established by the insurance commissioner in
14 consultation with the commission.

15 NEW SECTION. **Sec. 435.** PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--
16 FILING OF PREMIUMS AND ENROLLEE PAYMENT AMOUNTS--ADDITIONAL CHARGES
17 PROHIBITED. (1) The insurance commissioner shall verify that the
18 certified health plan and its providers are charging no more than the
19 maximum premiums and enrollee financial participation amounts during
20 the course of financial and market conduct examinations or more
21 frequently if justified in the opinion of the insurance commissioner or
22 upon request by the health services commission.

23 (2) The certified health plans shall file the premium schedules
24 including employer contributions, enrollee premium sharing, and
25 enrollee point of service cost sharing amounts with the insurance
26 commissioner, within thirty days of establishment by the health
27 services commission.

28 (3) No certified health plan or its provider may charge any fees,
29 assessments, or charges in addition to the premium amount or in excess
30 of the maximum enrollee financial participation limits established by
31 the health services commission. The certified health plan that
32 directly provides health care services may charge and collect the
33 enrollee point of service cost sharing fees as established in the
34 uniform benefits package or other approved benefit plan.

35 NEW SECTION. **Sec. 436.** ANNUAL STATEMENT FILING--CONTENTS--PENALTY
36 FOR FAILURE TO FILE--ACCURACY REQUIRED. (1) Every certified health
37 plan shall annually not later than March 1 of the calendar year, file

1 with the insurance commissioner a statement verified by at least two of
2 its principal officers showing its financial condition as of December
3 31 of the preceding year.

4 (2) Such annual report shall be in such form as the insurance
5 commissioner shall prescribe and shall include:

6 (a) A financial statement of the certified health plan, including
7 its balance sheet and receipts and disbursements for the preceding
8 year, which reflects at a minimum;

9 (i) All prepayments and other payments received for health care
10 services rendered pursuant to certified health plan benefit packages;

11 (ii) Expenditures to all categories of health care facilities,
12 providers, and organizations with which the plan has contracted to
13 fulfill obligations to enrolled residents arising out of the uniform
14 benefits package and other approved supplemental benefit agreements,
15 together with all other direct expenses including depreciation,
16 enrollment, and commission; and

17 (iii) Expenditures for capital improvements, or additions thereto,
18 including but not limited to construction, renovation, or purchase of
19 facilities and capital equipment;

20 (b) A report of the names and addresses of all officers, directors,
21 or trustees of the certified health plan during the preceding year, and
22 the amount of wages, expense reimbursements, or other payments to such
23 individuals;

24 (c) The number of residents enrolled and terminated during the
25 report period. Additional information regarding the enrollment and
26 termination pattern for a certified health plan may be required by the
27 commissioner to demonstrate compliance with the open enrollment and
28 free access requirements of chapter . . . , Laws of 1993 (this act).
29 The insurance commissioner shall specify additional information to be
30 reported, which may include but not be limited to age, sex, location,
31 and health status information;

32 (d) Such other information relating to the performance of the
33 certified health plan or the health care facilities or providers with
34 which it has contracted as reasonably necessary to the proper and
35 effective administration of this chapter in accordance with rules;

36 (e) Disclosure of any financial interests held by officers and
37 directors in any providers associated with the certified health plan or
38 provider of the certified health plan.

1 (3) The commissioner may require quarterly reporting of financial
2 information, such information to be furnished in a format prescribed by
3 the commissioner in consultation with the commission.

4 (4) The commissioner may for good reason allow a reasonable
5 extension of time within which such annual statement shall be filed.

6 (5) The commissioner may suspend or revoke the certificate of a
7 certified health plan for failing to file its annual statement when due
8 or during any extension of time therefor that the commissioner, for
9 good cause, may grant.

10 (6) The commissioner shall provide to the health services
11 commission an annual summary report of at least the information
12 required in subsections (2) and (3) of this section.

13 (7) No person may knowingly file with any public official or
14 knowingly make, publish, or disseminate any financial statement of a
15 certified health plan that does not accurately state the certified
16 health plan's financial condition.

17 NEW SECTION. **Sec. 437.** PROVIDER CONTRACTS--ENROLLED RESIDENT'S
18 LIABILITY, COMMISSIONER'S REVIEW. (1) Subject to subsection (2) of
19 this section, every contract between a certified health plan and its
20 providers of health care services shall be in writing and shall set
21 forth that in the event the certified health plan fails to pay for
22 health care services as set forth in the uniform benefits package, the
23 enrollee is not liable to the provider for any sums owed by the
24 certified health plan. Every such contract shall provide that this
25 requirement shall survive termination of the contract.

26 (2) The provisions of subsection (1) of this section shall not
27 apply to emergency care from a provider who is not a contracting
28 provider with the certified health plan, or to emergent and urgently
29 needed out-of-area services.

30 (3) The certified health plan shall file the contracts with the
31 insurance commissioner for approval thirty days prior to use.

32 NEW SECTION. **Sec. 438.** MINIMUM NET WORTH--REQUIREMENTS TO
33 MAINTAIN--DETERMINATION OF AMOUNT. (1) Every certified health plan
34 must maintain a minimum net worth equal to the greater of:

35 (a) One million dollars; or

36 (b) Two percent of annual premium revenues as reported on the most
37 recent annual financial statement filed with the insurance commissioner

1 on the first one hundred fifty million dollars of premium and one
2 percent of annual premium on the premium in excess of one hundred fifty
3 million dollars; or

4 (c) An amount equal to the sum of three months' uncovered
5 expenditures as reported on the most recent financial statement filed
6 with the commissioner.

7 (2)(a) In determining net worth, no debt may be considered fully
8 subordinated unless the subordination clause is in a form acceptable to
9 the commissioner. An interest obligation relating to the repayment of
10 a subordinated debt must be similarly subordinated.

11 (b) The interest expenses relating to the repayment of a fully
12 subordinated debt may not be considered uncovered expenditures.

13 (c) A subordinated debt incurred by a note meeting the requirements
14 of this section, and otherwise acceptable to the insurance
15 commissioner, may not be considered a liability and shall be recorded
16 as equity.

17 (3) Every certified health plan shall, in determining liabilities,
18 include an amount estimated in the aggregate to provide for unearned
19 premiums and for the payment of claims for health care expenditures
20 that have been incurred, whether reported or unreported, that are
21 unpaid and for which such organization is or may be liable and to
22 provide for the expense of adjustment or settlement of such claims.

23 The claims shall be computed in accordance with rules adopted by
24 the insurance commissioner in consultation with the health services
25 commission.

26 NEW SECTION. **Sec. 439.** FUNDED RESERVE REQUIREMENTS. (1) Each
27 certified health plan obtaining certification from the insurance
28 commissioner under sections 427 through 444 of this act shall provide
29 and maintain a funded reserve of one hundred fifty thousand dollars.
30 The funded reserve shall be deposited with the insurance commissioner
31 or with any organization acceptable to the commissioner in the form of
32 cash, securities eligible for investment under chapter 48.13 RCW,
33 approved surety bond, or any combination of these, and must be equal to
34 or exceed one hundred fifty thousand dollars. The funded reserve shall
35 be established as an assurance that the uncovered expenditures
36 obligations of the certified health plan to the enrolled Washington
37 residents shall be performed.

1 (2) All income from reserves on deposit with the commissioner shall
2 belong to the depositing certified health plan and shall be paid to it
3 as it becomes available.

4 (3) Funded reserves required by this section shall be considered an
5 asset in determining the plan's net worth.

6 NEW SECTION. **Sec. 440.** EXAMINATION OF CERTIFIED HEALTH PLANS,
7 POWERS OF COMMISSIONER, DUTIES OF PLANS, INDEPENDENT AUDIT REPORTS.

8 (1) The insurance commissioner shall make an examination of the
9 operations of a certified health plan as often as the commissioner
10 deems it necessary in order to assure the financial security and health
11 and safety of the enrolled residents. The insurance commissioner shall
12 make an examination of a certified health plan not less than once every
13 three calendar years.

14 (2) Every certified health plan shall submit its books and records
15 relating to its operation for financial condition and market conduct
16 examinations and in every way facilitate them. The quality or
17 appropriateness of health services and systems shall be examined by the
18 department of health except that the insurance commissioner may review
19 such areas to the extent that such items impact the financial condition
20 or the market conduct of the certified health plan. For the purpose of
21 the examinations the insurance commissioner may issue subpoenas,
22 administer oaths, and examine the officers and principals of the
23 certified health plans concerning their business.

24 (3) The insurance commissioner may elect to accept and rely on
25 audit reports made by an independent certified public accountant for
26 the certified health plan in the course of that part of the insurance
27 commissioner's examination covering the same general subject matter as
28 the audit. The commissioner may incorporate the audit report in his or
29 her report of the examination.

30 (4) Certified health plans shall be equitably assessed to cover the
31 cost of financial condition and market conduct examinations, the costs
32 of adopting rules, and the costs of enforcing the provisions of this
33 chapter. The assessments shall be levied not less frequently than
34 once every twelve months and shall be in an amount expected to fund the
35 examinations, adoption of rules, and enforcement of the provisions of
36 this chapter including a reasonable margin for cost variations. The
37 assessments shall be established by rules adopted by the commissioner
38 in consultation with the health services commission but may not exceed

1 five and one-half cents per month per resident enrolled in the
2 certified health plan. The minimum assessment shall be one thousand
3 dollars. Assessment receipts shall be deposited in the insurance
4 commissioner's regulatory account in the state treasury and shall be
5 used for the purpose of funding the examinations authorized in
6 subsection (1) of this section. Assessments received shall be used to
7 pay a pro rata share of the costs, including overhead of regulating
8 certified health plans. Amounts remaining in the separate account at
9 the end of a biennium shall be applied to reduce the assessments in
10 succeeding biennia.

11 NEW SECTION. **Sec. 441.** INSOLVENCY--COMMISSIONER'S DUTIES,
12 CONTINUATION OF BENEFITS, ALLOCATION OF COVERAGE. (1) In the event of
13 insolvency of a certified health plan and upon order of the
14 commissioner, all other certified health plans shall offer the enrolled
15 Washington residents of the insolvent certified health plan the
16 opportunity to enroll in a solvent certified health plan. Enrollment
17 shall be without prejudice for any preexisting condition and shall be
18 continuous provided the resident enrolls in the new certified health
19 plan within thirty days of the date of insolvency and otherwise
20 complies with the certified health plan's managed care procedures
21 within the thirty-day open enrollment period.

22 (2) The insurance commissioner, in consultation with the health
23 services commission, shall establish guidelines for the equitable
24 distribution of the insolvent certified health plan's enrollees to the
25 remaining certified health plans. The guidelines may include
26 limitations to enrollment based on financial conditions, provider
27 delivery network, administrative capabilities of the certified health
28 plan, and other reasonable measures of the certified health plan's
29 ability to provide benefits to the newly enrolled residents.

30 (3) Each certified health plan shall have a plan for handling
31 insolvency that allows for continuation of benefits for the duration of
32 the coverage period for which premiums have been paid and continuation
33 of benefits to enrolled Washington residents who are confined on the
34 date of insolvency in an inpatient facility until their discharge or
35 transfer to a new certified health plan as provided in subsection (1)
36 of this section. The plan shall be approved by the insurance
37 commissioner at the time of certification and shall be submitted for

1 review and approval on an annual basis. The commissioner shall approve
2 such a plan if it includes:

3 (a) Insurance to cover the expenses to be paid for continued
4 benefits after insolvency;

5 (b) Provisions in provider contracts that obligate the provider to
6 provide services for the duration of the period after the certified
7 health plan's insolvency for which premium payment has been made and
8 until the enrolled participant is transferred to a new certified health
9 plan in accordance with subsection (1) of this section. Such extension
10 of coverage shall not obligate the provider of service beyond thirty
11 days following the date of insolvency;

12 (c) Use of the funded reserve requirements as provided under
13 section 439 of this act;

14 (d) Acceptable letters of credit or approved surety bonds; or

15 (e) Other arrangements the insurance commissioner and certified
16 health plan mutually agree are appropriate to assure that benefits are
17 continued.

18 NEW SECTION. **Sec. 442.** FINANCIAL FAILURE, SUPERVISION OF
19 COMMISSIONER--PRIORITY OF DISTRIBUTION OF ASSETS. (1) Any
20 rehabilitation, liquidation, or conservation of a certified health plan
21 shall be deemed to be the rehabilitation, liquidation, or conservation
22 of an insurance company and shall be conducted under the supervision of
23 the insurance commissioner under the law governing the rehabilitation,
24 liquidation, or conservation of insurance companies. The insurance
25 commissioner may apply for an order directing the insurance
26 commissioner to rehabilitate, liquidate, or conserve a certified health
27 plan upon one or more of the grounds set forth in RCW 48.31.030,
28 48.31.050, and 48.31.080. Enrolled residents shall have the same
29 priority in the event of liquidation or rehabilitation as the law
30 provides to policyholders of an insurer.

31 (2) For purposes of determining the priority of distribution of
32 general assets, claims of enrolled residents and their dependents shall
33 have the same priority as established by RCW 48.31.280 for
34 policyholders and their dependents of insurance companies. If an
35 enrolled resident is liable to a provider for services under and
36 covered by a certified health plan, that liability shall have the
37 status of an enrolled resident claim for distribution of general
38 assets.

1 (3) A provider who is obligated by statute or agreement to hold
2 enrolled residents harmless from liability for services provided under
3 and covered by a certified health plan shall have a priority of
4 distribution of the general assets immediately following that of
5 enrolled residents and enrolled residents' dependents as described in
6 this section, and immediately proceeding the priority of distribution
7 described in RCW 48.31.280(2)(e).

8 NEW SECTION. **Sec. 443.** GRIEVANCE PROCEDURE. A certified health
9 plan shall establish and maintain a grievance procedure approved by the
10 commissioner, to provide a reasonable and effective resolution of
11 complaints initiated by enrolled Washington residents concerning any
12 matter relating to the provision of benefits under the uniform benefits
13 package, access to health care services, and quality of services. Each
14 certified health plan shall respond to complaints filed with the
15 insurance commissioner within twenty working days. The insurance
16 commissioner in consultation with the health services commission shall
17 establish standards for grievance procedures and resolution.

18 NEW SECTION. **Sec. 444.** EXEMPTION. The provisions of sections 433
19 through 443 of this act do not apply to any disability insurance
20 company, health care service contractor, or health maintenance
21 organization authorized to do business in Washington.

22 NEW SECTION. **Sec. 445.** ENFORCEMENT AUTHORITY OF COMMISSIONER.
23 For the purposes of chapter . . . , Laws of 1993 (this act), the
24 insurance commissioner shall have the same powers and duties of
25 enforcement as are provided in Title 48 RCW.

26 NEW SECTION. **Sec. 446.** ANNUAL REPORT BY THE INSURANCE
27 COMMISSIONER TO THE HEALTH SERVICES COMMISSION. Beginning January 1,
28 1997, the insurance commissioner shall report annually to the health
29 services commission on the compliance of certified health plans and
30 health insurance purchasing cooperatives with the provisions of chapter
31 . . . , Laws of 1993 (this act). The report shall include information
32 on (1) compliance with chapter . . . , Laws of 1993 (this act) open
33 enrollment and antidiscrimination provisions, (2) financial solvency
34 requirements, (3) the mix of enrollee characteristics within and among
35 plans and groups including age, sex, ethnicity, and any easily

1 obtainable information related to medical risk, (4) the geographic
2 distribution of plans and groups, and (5) other information that the
3 commission may request consistent with the goals of chapter . . . , Laws
4 of 1993 (this act).

5 **F. MANAGED COMPETITION AND LIMITED ANTI-TRUST IMMUNITY**

6 NEW SECTION. **Sec. 447.** MANAGED COMPETITION FINDINGS AND INTENT.

7 (1) The legislature recognizes that competition among health care
8 providers, facilities, payers, and purchasers will yield the best
9 allocation of health care resources, the lowest prices for health care,
10 and the highest quality of health care when there exists a large number
11 of buyers and sellers, easily comparable health care plans and
12 services, minimal barriers to entry and exit into the health care
13 market, and adequate information for buyers and sellers to base
14 purchasing and production decisions. However, the legislature finds
15 that purchasers of health care services and health care coverage do not
16 have adequate information upon which to base purchasing decisions; that
17 health care facilities and providers of health care services face legal
18 and market disincentives to develop economies of scale or to provide
19 the most cost-efficient and efficacious service; that health insurers,
20 contractors, and health maintenance organizations face market
21 disincentives in providing health care coverage to those Washington
22 residents with the most need for health care coverage; and that
23 potential competitors in the provision of health care coverage bear
24 unequal burdens in entering the market for health care coverage.

25 (2) The legislature therefore intends to exempt from state anti-
26 trust laws, and to provide immunity from federal anti-trust laws
27 through the state action doctrine for activities approved under this
28 chapter that might otherwise be constrained by such laws and intends to
29 displace competition in the health care market: To contain the
30 aggregate cost of health care services; to promote the development of
31 comprehensive, integrated, and cost-effective health care delivery
32 systems through cooperative activities among health care providers and
33 facilities; to promote comparability of health care coverage; to
34 improve the cost-effectiveness in providing health care coverage
35 relative to health promotion, disease prevention, and the amelioration
36 or cure of illness; to assure universal access to a publicly
37 determined, uniform package of health care benefits; and to create

1 reasonable equity in the distribution of funds, treatment, and medical
2 risk among purchasers of health care coverage, payers of health care
3 services, providers of health care services, health care facilities,
4 and Washington residents. To these ends, any lawful action taken
5 pursuant to chapter . . . , Laws of 1993 (this act) by any person or
6 entity created or regulated by chapter . . . , Laws of 1993 (this act)
7 are declared to be taken pursuant to state statute and in furtherance
8 of the public purposes of the state of Washington.

9 (3) The legislature does not intend and unless explicitly permitted
10 in accordance with section 448 of this act or under rules adopted
11 pursuant to chapter . . . , Laws of 1993 (this act), does not authorize
12 any person or entity to engage in activities or to conspire to engage
13 in activities that would constitute per se violations of state and
14 federal anti-trust laws including but not limited to conspiracies or
15 agreements:

16 (a) Among competing health care providers not to grant discounts,
17 not to provide services, or to fix the price of their services;

18 (b) Among certified health plans as to the price or level of
19 reimbursement for health care services;

20 (c) Among certified health plans to boycott a group or class of
21 health care service providers;

22 (d) Among purchasers of certified health plan coverage to boycott
23 a particular plan or class of plans;

24 (e) Among certified health plans to divide the market for health
25 care coverage; or

26 (f) Among certified health plans and purchasers to attract or
27 discourage enrollment of any Washington resident or groups of residents
28 in a certified health plan based upon the perceived or actual risk of
29 loss in including such resident or group of residents in a certified
30 health plan or purchasing group.

31 NEW SECTION. **Sec. 448.** COMPETITIVE OVERSIGHT AND ANTI-TRUST
32 IMMUNITY. (1) A certified health plan, health care facility, health
33 care provider, or other person involved in the development, delivery,
34 or marketing of health care or certified health plans may request, in
35 writing, that the commission obtain an informal opinion from the
36 attorney general as to whether particular conduct is authorized by
37 chapter . . . , Laws of 1993 (this act). The attorney general shall
38 issue such opinion within thirty days of receipt of a written request

1 for an opinion or within thirty days of receipt of any additional
2 information requested by the attorney general necessary for rendering
3 an opinion unless extended by the attorney general for good cause
4 shown. If the attorney general concludes that such conduct is not
5 authorized by chapter . . . , Laws of 1993 (this act), the person or
6 organization making the request may petition the commission for review
7 and approval of such conduct in accordance with subsection (3) of this
8 section.

9 (2) After obtaining the written opinion of the attorney general and
10 consistent with such opinion, the health services commission:

11 (a) May authorize conduct by a certified health plan, health care
12 facility, health care provider, or any other person that could tend to
13 lessen competition in the relevant market upon a strong showing that
14 the conduct is likely to achieve the policy goals of chapter . . . ,
15 Laws of 1993 (this act) and a more competitive alternative is
16 impractical;

17 (b) Shall adopt rules governing conduct among providers, health
18 care facilities, and certified health plans including rules governing
19 provider and facility contracts with certified health plans, rules
20 governing the use of "most favored nation" clauses and exclusive
21 dealing clauses in such contracts, and rules providing that certified
22 health plans in rural areas contract with a sufficient number and type
23 of health care providers and facilities to ensure consumer access to
24 local health care services;

25 (c) Shall adopt rules permitting health care providers within the
26 service area of a plan to collectively negotiate the terms and
27 conditions of contracts with a certified health plan including the
28 ability of providers to meet and communicate for the purposes of these
29 negotiations; and

30 (d) Shall adopt rules governing cooperative activities among health
31 care facilities and providers.

32 (3) A certified health plan, health care facility, health care
33 provider, or any other person involved in the development, delivery,
34 and marketing of health services or certified health plans may file a
35 written petition with the commission requesting approval of conduct
36 that could tend to lessen competition in the relevant market. Such
37 petition shall be filed in a form and manner prescribed by rule of the
38 commission.

1 The commission shall issue a written decision approving or denying
2 a petition filed under this section within ninety days of receipt of a
3 properly completed written petition unless extended by the commission
4 for good cause shown. The decision shall set forth findings as to
5 benefits and disadvantages and conclusions as to whether the benefits
6 outweigh the disadvantages.

7 (4) In authorizing conduct and adopting rules of conduct under this
8 section, the commission with the advice of the attorney general, shall
9 consider the benefits of such conduct in furthering the goals of health
10 care reform including but not limited to:

- 11 (a) Enhancement of the quality of health services to consumers;
- 12 (b) Gains in cost efficiency of health services;
- 13 (c) Improvements in utilization of health services and equipment;
- 14 (d) Avoidance of duplication of health services resources; or
- 15 (e) And as to subsections (b) and (c) of this subsection: (i)
16 Facilitates the exchange of information relating to performance
17 expectations; (ii) simplifies the negotiation of delivery arrangements
18 and relationships; and (iii) reduces the transactions costs on the part
19 of certified health plans and providers in negotiating more cost
20 effective delivery arrangements.

21 These benefits must outweigh disadvantages including and not
22 limited to:

- 23 (i) Reduced competition among certified health plans, health care
24 providers, or health care facilities;
- 25 (ii) Adverse impact on quality, availability, or price of health
26 care services to consumers; or
- 27 (iii) The availability of arrangements less restrictive to
28 competition that achieve the same benefits.

29 (5) Conduct authorized by the commission shall be deemed taken
30 pursuant to state statute and in the furtherance of the public purposes
31 of the state of Washington.

32 (6) With the assistance of the attorney general's office, the
33 commission shall actively supervise any conduct authorized under this
34 section to determine whether such conduct or rules permitting certain
35 conduct should be continued and whether a more competitive alternative
36 is practical. The commission shall periodically review petitioned
37 conduct through, at least, annual progress reports from petitioners,
38 annual or more frequent reviews by the commission that evaluate whether
39 the conduct is consistent with the petition, and whether the benefits

1 continue to outweigh any disadvantages. If the commission determines
2 that the likely benefits of any conduct approved through rule,
3 petition, or otherwise by the commission no longer outweigh the
4 disadvantages attributable to potential reduction in competition, the
5 commission shall order a modification or discontinuance of such
6 conduct. Conduct ordered discontinued by the commission shall no
7 longer be deemed to be taken pursuant to state statute and in the
8 furtherance of the public purposes of the state of Washington.

9 (7) Nothing contained in chapter . . . , Laws of 1993 (this act) is
10 intended to in any way limit the ability of rural hospital districts to
11 enter into cooperative agreements and contracts pursuant to RCW
12 70.44.450 and chapter 39.34 RCW.

13 **G. THE UNIFORM BENEFITS PACKAGE**

14 NEW SECTION. **Sec. 449.** UNIFORM BENEFITS PACKAGE DESIGN. (1) The
15 commission shall define the uniform benefits package, which shall
16 include those health services that, consistent with the goals and
17 intent of chapter . . . , Laws of 1993 (this act), are effective and
18 necessary on a societal basis for the maintenance of the health of
19 citizens of the state, weighed against the need to control state health
20 services expenditures.

21 (2) The schedule of covered health services shall emphasize proven
22 preventive and primary health care and shall be composed of the
23 following essential health services: (a) Primary and specialty health
24 services; (b) inpatient and outpatient hospital services; (c)
25 prescription drugs and medications; (d) reproductive services; (e)
26 services necessary for maternity and well-child care, including
27 preventive dental services for children; and (f) case-managed chemical
28 dependency, mental health, short-term skilled nursing facility, home
29 health, and hospice services, to the extent that such services reduce
30 inappropriate utilization of more intensive or less efficacious medical
31 services. The commission shall determine the specific schedule of
32 health services within the uniform benefits package, including
33 limitations on scope and duration of services. The schedule shall be
34 the benefit and actuarial equivalent of the schedule of benefits
35 offered by the basic health plan on January 1, 1993, including any
36 additions that may result from the inclusion of the services listed in
37 (c) through (f) of this subsection. The commission shall consider the

1 recommendations of health services effectiveness panels established
2 pursuant to section 404 of this act in defining the uniform benefits
3 package.

4 (3) The uniform benefits package shall not limit coverage for
5 preexisting or prior conditions, except that the commission shall
6 establish exclusions for preexisting or prior conditions to the extent
7 necessary to prevent residents from waiting until health services are
8 needed before enrolling in a certified health plan.

9 (4) The commission shall establish enrollee point of service cost-
10 sharing for nonpreventive health services, related to enrollee
11 household income, such that financial considerations are not a barrier
12 to access for low-income persons, but that, for those of means, the
13 uniform benefits package provides for moderate point of service cost-
14 sharing. All point of service cost-sharing and cost control
15 requirements shall apply uniformly to all health care providers
16 providing substantially similar uniform benefits package services. The
17 schedule shall provide for an alternate and lower schedule of cost-
18 sharing applicable to enrollees with household income below the federal
19 poverty level.

20 (5) The commission shall adopt rules related to coordination of
21 benefits and premium payments. The rules shall not have the effect of
22 eliminating enrollee financial participation. The commission shall
23 endeavor to assure an equitable distribution, among both employers and
24 employees, of the costs of coverage for those households composed of
25 more than one member in the work force.

26 (6) In determining the uniform benefits package, the commission
27 shall endeavor to seek the opinions of and information from the public.
28 The commission shall consider the results of official public health
29 assessment and policy development activities including recommendations
30 of the department of health in discharging its responsibilities under
31 this section.

32 (7) The commission shall submit the following to the legislature by
33 December 1, 1994, and by December 1 of the year preceding any year in
34 which the commission proposes to significantly modify the uniform
35 benefits package: (a) The uniform benefits package; and (b) an
36 independent actuarial analysis of the cost of the proposed package,
37 giving consideration to the factors considered under section 406(6) of
38 this act. The commission shall not modify the services included in the
39 uniform benefits package before January 1, 1999.

1 NEW SECTION. **Sec. 450.** SMALL BUSINESS ECONOMIC IMPACT STATEMENT.

2 (1) In conjunction with submission of the uniform benefits package as
3 provided in section 449(7) of this act, the commission also shall
4 submit a small business economic impact statement, prepared in
5 consultation with the small business advisory committee. The impact
6 statement shall address the economic impact on businesses with twenty-
7 five or fewer full-time equivalent employees of participating in the
8 cost of the uniform benefits package for their employees and employees'
9 dependents. As an aid in preparing the small business economic impact
10 statement, the commission shall conduct a survey of a statistically
11 valid sample of small businesses.

12 (2) If the small business economic impact statement indicates a
13 need to address the economic consequences of mandating employer
14 participation in the cost of uniform benefits package coverage for
15 employees and their dependents, the commission shall submit proposed
16 strategies to address such consequences. Strategies may include: The
17 level of employer participation in uniform benefits package costs;
18 coverage of dependents; application of the uniform benefits package as
19 the minimum benefits package offered to employees or dependents; and
20 any other strategies deemed appropriate by the commission.

21 NEW SECTION. **Sec. 451.** HOUSEHOLD INCOME ANALYSIS. In conjunction
22 with submission of the uniform benefits package as provided in section
23 449(7) of this act, the commission shall submit an analysis of the
24 impact of employee premium contributions on individuals with household
25 income of less than two hundred percent of the federal poverty level.
26 The analysis shall include estimates of the cost of varying levels of
27 premium subsidies for these individuals and their families.

28 NEW SECTION. **Sec. 452.** CERTIFIED HEALTH PLAN BENEFIT PACKAGES--
29 OFFERING, FILING, AND APPROVAL OF FORMS. No uniform benefits package
30 or supplemental benefits may be offered, delivered, or issued for
31 delivery to any person in this state unless it otherwise complies with
32 chapter . . . , Laws of 1993 (this act), and complies with the
33 following:

34 (1) All certified health plan forms for uniform and supplemental
35 benefits issued by the plan to enrollees and such other marketing
36 documents purporting to describe the plan's benefits shall comply with
37 the minimum standards the commissioner deems reasonable and necessary

1 to carry out the purposes and provisions of this chapter and consistent
2 with health services commission standards. The plan's forms and
3 documents shall fully inform enrollees of the health services to which
4 they are entitled, and shall fully disclose any limitations,
5 exclusions, rights, responsibilities, and duties required of either the
6 enrollee or the certified health plan. No form or document may be
7 issued, delivered, or issued for delivery unless it has been filed with
8 and approved by the commissioner.

9 (2) Every form or document filing containing a certification, in a
10 manner approved by the commissioner, by either the chief executive
11 officer of the plan or by an actuary who is a member of the American
12 academy of actuaries, attesting that the filing complies with Title 48
13 RCW, Title 284 WAC, and this chapter, may be used by such certified
14 health plan immediately after filing with the commissioner. The
15 commissioner may order a plan to cease using a certified form or
16 document upon the grounds set forth in subsection (6) of this section.

17 (3) Every filing that does not contain a certification pursuant to
18 subsection (2) of this section shall be made not less than thirty days
19 in advance of any such issuance, delivery, or use. At the expiration
20 of such thirty days the form or document filed shall be deemed approved
21 unless affirmatively approved or disapproved by the commissioner within
22 the thirty-day period. The commissioner may extend by not more than an
23 additional fifteen days the period within which the commissioner may
24 review such filing, by notifying the plan of the extension before
25 expiration of the initial thirty-day period. At the expiration of any
26 extension period and in the absence of prior affirmative approval or
27 disapproval, any such form or document shall be deemed approved. The
28 commissioner may withdraw approval at any time for cause. By approval
29 of any filing for immediate use, the commissioner may waive any
30 unexpired portion of the initial thirty-day waiting period.

31 (4) Whenever the commissioner disapproves a filing or withdraws a
32 previous approval, the commissioner shall state the grounds for
33 disapproval.

34 (5) The commissioner may exempt from the requirements of this
35 section any plan document or form that, in the commissioner's opinion,
36 may not practicably be applied to, or the filing and approval of which
37 are, in the commissioner's opinion, not desirable or necessary for the
38 protection of the public.

1 (6) The commissioner shall disapprove any form or document or shall
2 withdraw any previous approval, only:

3 (a) If it is in any respect in violation of or does not comply with
4 Title 48 RCW, Title 284 WAC, and this chapter, or any applicable order
5 of the commissioner;

6 (b) If it does not comply with any controlling filing previously
7 made and approved;

8 (c) If it contains or incorporates by reference any inconsistent,
9 ambiguous, or misleading clauses, or exceptions and conditions that
10 unreasonably or deceptively affect the health services purported to be
11 offered or provided;

12 (d) If it has any title, heading, or other indication of its
13 provisions that is misleading;

14 (e) If purchase of health services under the form or document is
15 being solicited by deceptive advertising; or

16 (f) If the health service benefits provided in the form or document
17 are unreasonable in relation to the premium charged.

18 NEW SECTION. Sec. 453. UNIFORM AND SUPPLEMENTAL BENEFITS--RATES--
19 FILING AND APPROVAL. (1) Premium rates for uniform benefits package
20 and supplemental benefits shall not be excessive or inadequate, and
21 shall not discriminate in a manner prohibited by section 428(3) of this
22 act. Premium rates, enrollee point of service cost-sharing, or maximum
23 enrollee financial participation amounts for a uniform benefits package
24 may not exceed the limits established by the health services commission
25 in accordance with section 406 of this act. Premium rates for uniform
26 benefits package and supplemental benefits shall be developed on a
27 community-rated basis as determined by the health services commission.

28 (2) Prior to using, every certified health plan shall file with the
29 commissioner its enrollee point of service, cost-sharing amounts,
30 enrollee financial participation amounts, rates, its rating plan, and
31 any other information used to determine the specific premium to be
32 charged any enrollee and every modification of any of the foregoing.

33 (3) Every such filing shall indicate the type and extent of the
34 health services contemplated and must be accompanied by sufficient
35 information to permit the commissioner to determine whether it meets
36 the requirements of this chapter. A plan shall offer in support of any
37 filing:

1 (a) Any historical data and actuarial projections used to establish
2 the rate filed;

3 (b) An exhibit detailing the major elements of operating expense
4 for the types of health services affected by the filing;

5 (c) An explanation of how investment income has been taken into
6 account in the proposed rates;

7 (d) Any other information that the plan deems relevant; and

8 (e) Any other information that the commissioner requires by rule.

9 (4) If a plan has insufficient loss experience to support its
10 proposed rates, it may submit loss experience for similar exposures of
11 other plans within the state.

12 (5) Every filing shall state its proposed effective date.

13 (6) Actuarial formulas, statistics, and assumptions submitted in
14 support of a rate or form filing by a plan or submitted to the
15 commissioner at the commissioner's request shall be withheld from
16 public inspection in order to preserve trade secrets or prevent unfair
17 competition.

18 (7) No plan may make or issue a benefits package except in
19 accordance with its filing then in effect.

20 (8) The commissioner shall review a filing as soon as reasonably
21 possible after made, to determine whether it meets the requirements of
22 this section.

23 (9)(a) No filing may become effective within thirty days after the
24 date of filing with the commissioner, which period may be extended by
25 the commissioner for an additional period not to exceed fifteen days if
26 the commissioner gives notice within such waiting period to the plan
27 that the commissioner needs additional time to consider the filing.

28 (b) A filing shall be deemed to meet the requirements of this
29 section unless disapproved by the commissioner within the waiting
30 period or any extension period.

31 (c) If within the waiting or any extension period, the commissioner
32 finds that a filing does not meet the requirements of this section, the
33 commissioner shall disapprove the filing, shall notify the plan of the
34 grounds for disapproval, and shall prohibit the use of the disapproved
35 filing.

36 (10) If at any time after the applicable review period provided in
37 this section, the commissioner finds that a filing does not meet the
38 requirements of this section, the commissioner shall, after notice and
39 hearing, issue an order specifying in what respect the commissioner

1 finds that such filing fails to meet the requirements of this section,
2 and stating when, within a reasonable period thereafter, the filings
3 shall be deemed no longer effective.

4 The order shall not affect any benefits package made or issued
5 prior to the expiration of the period set forth in the order.

6 NEW SECTION. **Sec. 454.** The legislature may disapprove of the
7 uniform benefits package developed under section 449 of this act and
8 medical risk adjustment mechanisms developed under section 406(7) of
9 this act by an act of law at any time prior to the thirtieth day of the
10 following regular legislative session. If such disapproval action is
11 taken, the commission shall resubmit a modified package to the
12 legislature within fifteen days of the disapproval. If the legislature
13 does not disapprove or modify the package by an act of law by the end
14 of that regular session, the package is deemed approved.

15 NEW SECTION. **Sec. 455.** SUPPLEMENTAL AND ADDITIONAL BENEFITS
16 NEGOTIATION. (1) Nothing in chapter . . . , Laws of 1993 (this act)
17 shall preclude insurers, health care service contractors, health
18 maintenance organizations, or certified health plans from insuring,
19 providing, or contracting for benefits not included in the uniform
20 benefits package or in supplemental benefits.

21 (2) Nothing in chapter . . . , Laws of 1993 (this act) shall
22 restrict the right of an employer to offer, an employee representative
23 to negotiate for, or an individual to purchase supplemental or
24 additional benefits not included in the uniform benefits package.

25 (3) Nothing in chapter . . . , Laws of 1993 (this act) shall
26 restrict the right of an employer to offer or an employee
27 representative to negotiate for payment of up to one hundred percent of
28 the premium of the lowest priced uniform benefits package available in
29 the geographic area where the employer is located.

30 (4) Nothing in chapter . . . , Laws of 1993 (this act) shall be
31 construed to affect the collective bargaining rights of employee
32 organizations to the extent that federal law specifically restricts the
33 ability of states to limit collective bargaining rights of employee
34 organizations.

35 (5) After July 1, 1999, no property or casualty insurance policy
36 issued in this state may provide first-party coverage for health
37 services to the extent that such services are provided under a uniform

1 benefits package covering the resident to whom such property or
2 casualty insurance policy is issued.

3 NEW SECTION. **Sec. 456.** CONSCIENCE OR RELIGION. (1) No certified
4 health plan or health care provider may be required by law or contract
5 in any circumstances to participate in the provision of any uniform
6 benefit if they object to so doing for reason of conscience or
7 religion. No person may be discriminated against in employment or
8 professional privileges because of such objection.

9 (2) The provisions of this section are not intended to result in an
10 enrollee being denied timely access to any service included in the
11 uniform benefits package. Each certified health plan shall:

12 (a) Provide written notice to certified health plan enrollees, upon
13 enrollment with the plan and upon enrollee request thereafter, listing,
14 by provider, services that any provider refuses to perform for reason
15 of conscience or religion;

16 (b) Develop written information describing how an enrollee may
17 directly access, in an expeditious manner, services that a provider
18 refuses to perform; and

19 (c) Ensure that enrollees refused services under this section have
20 prompt access to the information developed pursuant to (b) of this
21 subsection.

22 NEW SECTION. **Sec. 457.** LONG-TERM CARE INTEGRATION PLAN. (1) To
23 meet the health needs of the residents of Washington state, it is
24 critical to finance and provide long-term care and support services
25 through an integrated, comprehensive system that promotes human dignity
26 and recognizes the individuality of all functionally disabled persons.
27 This system shall be available, accessible, and responsive to all
28 residents based upon an assessment of their functional disabilities.
29 The governor and the legislature recognize that families, volunteers,
30 and community organizations are essential for the delivery of effective
31 and efficient long-term care and support services, and that this
32 private and public service infrastructure should be supported and
33 strengthened. Further, it is important to provide benefits without
34 requiring family or program beneficiary impoverishment for service
35 eligibility.

36 (2) To realize the need for a strong long-term care system and to
37 carry out the November 30, 1992, final recommendations of the

1 Washington health care cost control and access commission, established
2 under House Concurrent Resolution No. 4443 adopted by the legislature
3 in 1990, related to long-term care, the commission shall:

4 (a) Engage in a planning process, in conjunction with an advisory
5 committee appointed for this purpose, for the inclusion of long-term
6 care services in the uniform benefits package established under section
7 449 of this act by July 1999;

8 (b) Include in its planning process consideration of the scope of
9 services to be covered, the cost of and financing of such coverage, the
10 means through which existing long-term care programs and delivery
11 systems can be coordinated and integrated, and the means through which
12 family members can be supported in their role as informal caregivers
13 for their parents, spouses, or other relatives.

14 (3) The commission shall submit recommendations concerning any
15 necessary statutory changes or modifications of public policy to the
16 governor and the legislature by January 1, 1995.

17 (4) The departments of health, retirement systems, revenue, social
18 and health services, and veterans' affairs, the offices of financial
19 management, insurance commissioner, and state actuary, along with the
20 health care authority, shall participate in the review of the long-term
21 care needs enumerated in this section and provide necessary supporting
22 documentation and staff expertise as requested by the commission.

23 (5) The commission shall include in its planning process, the
24 development of two social health maintenance organization long-term
25 care pilot projects. The two pilot projects shall be referred to as
26 the Washington life care pilot projects. Each life care pilot program
27 shall be a single-entry system administered by an individual
28 organization that is responsible for bringing together a full range of
29 medical and long-term care services. The commission, in coordination
30 with the appropriate agencies and departments, shall establish a
31 Washington life care benefits package that shall include the uniform
32 benefits package established in chapter . . . , Laws of 1993 (this act)
33 and long-term care services. The Washington life care benefits package
34 shall include, but not be limited to, the following long-term care
35 services: Case management, intake and assessment, nursing home care,
36 adult family home care, home health and home health aide care, hospice,
37 chore services/homemaker/personal care, adult day care, respite care,
38 and appropriate social services. The pilot project shall develop

1 assessment and case management protocol that emphasize home and
2 community-based care long-term care options.

3 (a) In designing the pilot projects, the commission shall address
4 the following issues: Costs for the long-term care benefits, a
5 projected case-mix based upon disability, the required federal waiver
6 package, reimbursement, capitation methodology, marketing and
7 enrollment, management information systems, identification of the most
8 appropriate case management models, provider contracts, and the
9 preferred organizational design that will serve as a functioning model
10 for efficiently and effectively transitioning long-term care services
11 into the uniform benefits package established in chapter . . . , Laws of
12 1993 (this act). The commission shall also be responsible for
13 establishing the size of the two membership pools.

14 (b) Each program shall enroll applicants based on their level of
15 functional disability and personal care needs. The distribution of
16 these functional level categories and ethnicity within the enrolled
17 program population shall be representative of their distribution within
18 the community, using the best available data to estimate the community
19 distributions.

20 (c) The two sites selected for the Washington life care pilot
21 program shall be drawn from the largest urban areas and include one
22 site in the eastern part of the state and one site in the western part
23 of the state. The two organizations selected to manage and coordinate
24 the life care services shall have the proven ability to provide
25 ambulatory care, personal care/chore services, dental care, case
26 management and referral services, must be accredited and licensed to
27 provide long-term care for home health services, and may be licensed to
28 provide nursing home care.

29 (d) The report on the development and establishment date of the two
30 social health maintenance organizations shall be submitted to the
31 governor and appropriate committees of the legislature by September 16,
32 1994. If the necessary federal waivers cannot be secured by January 1,
33 1995, the commission may elect to not establish the two pilot programs.

34 NEW SECTION. **Sec. 458.** WASHINGTON LONG-TERM CARE PARTNERSHIP.
35 The department of social and health services shall from July 1, 1993,
36 to July 1, 1998, coordinate a pilot program entitled the Washington
37 long-term care partnership, whereby private insurance and medicaid
38 funds shall be used to finance long-term care. This program must allow

1 for the exclusion of an individual's assets, as approved by the federal
2 health care financing administration, in a determination of the
3 individual's eligibility for medicaid; the amount of any medicaid
4 payment; or any subsequent recovery by the state for a payment for
5 medicaid services to the extent such assets are protected by a long-
6 term care insurance policy or contract governed by chapter 48.84 RCW
7 and meeting the criteria prescribed in this chapter.

8 NEW SECTION. **Sec. 459.** WASHINGTON LONG-TERM CARE PARTNERSHIP.

9 The department of social and health services shall seek approval and a
10 waiver of appropriate federal medicaid regulations to allow the
11 protection of an individual's assets as provided in this chapter. The
12 department shall adopt all rules necessary to implement the Washington
13 long-term care partnership program, which rules shall permit the
14 exclusion of an individual's assets in a determination of medicaid
15 eligibility to the extent that private long-term care insurance
16 provides payment or benefits for services that medicaid would approve
17 or cover for medicaid recipients.

18 NEW SECTION. **Sec. 460.** WASHINGTON LONG-TERM CARE PARTNERSHIP.

19 (1) The insurance commissioner shall adopt rules defining the criteria
20 that long-term care insurance policies must meet to satisfy the
21 requirements of this chapter. The rules shall provide that all long-
22 term care insurance policies purchased for the purposes of this
23 chapter:

24 (a) Be guaranteed renewable;

25 (b) Provide coverage for home and community-based services and
26 nursing home care;

27 (c) Provide automatic inflation protection or similar coverage to
28 protect the policyholder from future increases in the cost of long-term
29 care;

30 (d) Not require prior hospitalization or confinement in a nursing
31 home as a prerequisite to receiving long-term care benefits; and

32 (e) Contain at least a six-month grace period that permits
33 reinstatement of the policy or contract retroactive to the date of
34 termination if the policy or contract holder's nonpayment of premiums
35 arose as a result of a cognitive impairment suffered by the policy or
36 contract holder as certified by a physician.

1 (2) Insurers offering long-term care policies for the purposes of
2 this chapter shall demonstrate to the satisfaction of the insurance
3 commissioner that they:

4 (a) Have procedures to provide notice to each purchaser of the
5 long-term care consumer education program;

6 (b) Offer case management services;

7 (c) Have procedures that provide for the keeping of individual
8 policy records and procedures for the explanation of coverage and
9 benefits identifying those payments or services available under the
10 policy that meet the purposes of this chapter;

11 (d) Agree to provide the insurance commissioner, on or before
12 September 1 of each year, an annual report containing the following
13 information:

14 (i) The number of policies issued and of the policies issued, that
15 number sorted by issue age;

16 (ii) To the extent possible, the financial circumstance of the
17 individuals covered by such policies;

18 (iii) The total number of claims paid; and

19 (iv) Of the number of claims paid, the number paid for nursing home
20 care, for home care services, and community-based services.

21 NEW SECTION. **Sec. 461.** WASHINGTON LONG-TERM CARE PARTNERSHIP.
22 The insurance commissioner, in conjunction with the department of
23 social and health services, shall develop a consumer education program
24 designed to educate consumers as to the need for long-term care,
25 methods for financing long-term care, the availability of long-term
26 care insurance, and the availability and eligibility requirements of
27 the asset protection program provided under this chapter.

28 NEW SECTION. **Sec. 462.** WASHINGTON LONG-TERM CARE PARTNERSHIP. By
29 January 1 of each year, the insurance commissioner, in conjunction with
30 the department of social and health services, shall report to the
31 legislature on the progress of the asset protection program. The
32 report shall include:

33 (1) The success of the agencies in implementing the program;

34 (2) The number of insurers offering long-term care policies meeting
35 the criteria for asset protection;

1 (3) The number, age, and financial circumstances of individuals
2 purchasing long-term care policies meeting the criteria for asset
3 protection;

4 (4) The number of individuals seeking consumer information
5 services;

6 (5) The extent and type of benefits paid by insurers offering
7 policies meeting the criteria for asset protection;

8 (6) Estimates of the impact of the program on present and future
9 medicaid expenditures;

10 (7) The cost-effectiveness of the program; and

11 (8) A determination regarding the appropriateness of continuing the
12 program.

13 H. STATE RESIDENT AND EMPLOYER PARTICIPATION

14 NEW SECTION. **Sec. 463.** INDIVIDUAL PARTICIPATION. (1) All
15 residents of the state of Washington are required to purchase a uniform
16 benefits package from a certified health plan no later than July 1,
17 1999. This participation requirement shall be waived if imposition of
18 the requirement would constitute a violation of the freedom of religion
19 provisions set forth in the First Amendment, United States Constitution
20 or Article I, section 11 of the state Constitution. Residents of the
21 state of Washington who work in another state for an out-of-state
22 employer shall be deemed to have satisfied the requirements of this
23 section if they receive health insurance coverage through such
24 employer.

25 (2) The commission shall monitor the enrollment of individuals into
26 certified health plans and shall make public periodic reports
27 concerning the number of persons enrolled and not enrolled, the reasons
28 why individuals are not enrolled, recommendations to reduce the number
29 of persons not enrolled, and recommendations regarding enforcement of
30 this provision.

31 NEW SECTION. **Sec. 464.** EMPLOYER PARTICIPATION. (1) The
32 legislature recognizes that small businesses play an essential and
33 increasingly important role in the state's economy. The legislature
34 further recognizes that many of the state's small business owners
35 provide health insurance to their employees through small group
36 policies at a cost that directly affects their profitability. Other

1 small business owners are prevented from providing health benefits to
2 their employees by the lack of access to affordable health insurance
3 coverage. The legislature intends that the provisions of chapter
4 . . . , Laws of 1993 (this act) make health insurance more available and
5 affordable to small businesses in Washington state through strong cost
6 control mechanisms and the option to purchase health benefits through
7 the basic health plan, the Washington state group purchasing
8 association, and health insurance purchasing cooperatives.

9 (2) On July 1, 1995, every employer employing more than five
10 hundred qualified employees shall:

11 (a) Offer a choice of the uniform benefits package as provided by
12 at least three available certified health plans, one of which shall be
13 the lowest cost available package within their geographic region, and
14 for employers who have established a registered employer health plan,
15 one of which may be its own registered employer health plan, to all
16 qualified employees. The employer shall be required to pay no less
17 than fifty percent of the premium cost of the lowest cost available
18 package within their geographic region. On July 1, 1996, all
19 dependents of qualified employees of these firms shall be offered a
20 choice of packages as provided in this section with the employer paying
21 no less than fifty percent of the premium of the lowest cost package
22 within their geographic region.

23 (b) For employees who work fewer than thirty hours during a week or
24 one hundred twenty hours during a calendar month, three hundred sixty
25 hours during a calendar quarter or one thousand four hundred forty
26 hours during a calendar year, and their dependents, pay, for the period
27 of time adopted by the employer under this subsection, the amount
28 resulting from application of the following formula: The number of
29 hours worked by the employee in a month is multiplied by the amount of
30 a qualified employee's premium, and that amount is then divided by one
31 hundred twenty.

32 (c) If an employee under (b) of this subsection is the dependent of
33 a qualified employee, and is therefore covered as a dependent by the
34 qualified employee's employer, then the employer of the employee under
35 (b) of this subsection shall not be required to participate in the cost
36 of the uniform benefits package for that employee.

37 (d) If an employee working on a seasonal basis is a qualified
38 employee of another employer, and therefore has uniform benefits
39 package coverage through that primary employer, then the seasonal

1 employer of the employee shall not be required to participate in the
2 cost of the uniform benefits package for that employee.

3 (3) By July 1, 1996, every employer employing more than one hundred
4 qualified employees shall:

5 (a) Offer a choice of the uniform benefits package as provided by
6 at least three available certified health plans, one of which shall be
7 the lowest cost available package within their geographic region, to
8 all qualified employees. The employer shall be required to pay no less
9 than fifty percent of the premium cost of the lowest cost available
10 package within their geographic region. On July 1, 1997, all
11 dependents of qualified employees in these firms shall be offered a
12 choice of packages as provided in this section with the employer paying
13 no less than fifty percent of the premium of the lowest cost package
14 within their geographic region.

15 (b) For employees who work fewer than thirty hours during a week or
16 one hundred twenty hours during a calendar month, three hundred sixty
17 hours during a calendar quarter or one thousand four hundred forty
18 hours during a calendar year, and their dependents, pay, for the period
19 of time adopted by the employer under this subsection, the amount
20 resulting from application of the following formula: The number of
21 hours worked by the employee in a month is multiplied by the amount of
22 a qualified employee's premium, and that amount is then divided by one
23 hundred twenty.

24 (c) If an employee under (b) of this subsection is the dependent of
25 a qualified employee, and is therefore covered as a dependent by the
26 qualified employee's employer, then the employer of the employee under
27 (b) of this subsection shall not be required to participate in the cost
28 of the uniform benefits package for that employee.

29 (d) If an employee working on a seasonal basis is a qualified
30 employee of another employer, and therefore has uniform benefits
31 package coverage through that primary employer, then the seasonal
32 employer of the employee shall not be required to participate in the
33 cost of the uniform benefits package for that employee.

34 (4) By July 1, 1997, every employer shall:

35 (a) Offer a choice of the uniform benefits package as provided by
36 at least three available certified health plans, one of which shall be
37 the lowest cost available package within their geographic region, to
38 all qualified employees. The employer shall be required to pay no less
39 than fifty percent of the premium cost of the lowest cost available

1 package within their geographic region. On July 1, 1999, all
2 dependents of qualified employees in all firms shall be offered a
3 choice of packages as provided in this section with the employer paying
4 no less than fifty percent of the premium of the lowest cost package
5 within their geographic region.

6 (b) For employees who work fewer than thirty hours during a week or
7 one hundred twenty hours during a calendar month, three hundred sixty
8 hours during a calendar quarter or one thousand four hundred forty
9 hours during a calendar year, and their dependents, pay, for the period
10 of time adopted by the employer under this subsection, the amount
11 resulting from application of the following formula: The number of
12 hours worked by the employee in a month is multiplied by the amount of
13 a qualified employee's premium, and that amount is then divided by one
14 hundred twenty.

15 (c) If an employee under (b) of this subsection is the dependent of
16 a qualified employee, and is therefore covered as a dependent by the
17 qualified employee's employer, then the employer of the employee under
18 (b) of this subsection shall not be required to participate in the cost
19 of the uniform benefits package for that employee.

20 (d) If an employee working on a seasonal basis is a qualified
21 employee of another employer, and therefore has uniform benefits
22 package coverage through that primary employer, then the seasonal
23 employer of the employee shall not be required to participate in the
24 cost of the uniform benefits package for that employee.

25 (5) This employer participation requirement shall be waived if
26 imposition of the requirement would constitute a violation of the
27 freedom of religion provisions of the First Amendment of the United
28 States Constitution or Article I, section 11, of the state
29 Constitution. In such case the employer shall, pursuant to commission
30 rules, set aside an amount equal to the applicable employer
31 contribution level in a manner that would permit his or her employee to
32 fully comply with the requirements of this chapter.

33 (6) In lieu of offering the uniform benefits package to employees
34 and their dependents through direct contracts with certified health
35 plans, an employer may combine the employer contribution with that of
36 the employee's contribution and enroll in the basic health plan as
37 provided in chapter 70.47 RCW or a health insurance purchasing
38 cooperative established under sections 425 and 426 of this act.

1 NEW SECTION. **Sec. 465.** DEPOSITORY. (1) The health care
2 authority shall establish a depository where payments under section 464
3 of this act can be made and held in safekeeping for the benefit of
4 employees working less than the number of hours worked by a qualified
5 employee.

6 (2) The authority shall adopt appropriate rules for operation of
7 the depository, in consultation with representatives of employees and
8 employers, especially those that are seasonal or employ large numbers
9 of part-time workers. The rules shall address the means through which
10 payments will be properly deposited to the credit of employees and the
11 means through which employees can access payments made on their behalf.
12 On and after July 1, 1995, payments deposited by employers on behalf of
13 employees may be used by employees only for purchase of the uniform
14 benefits package. Prior to July 1, 1995, payments may be used for
15 purchase of any health insurance coverage.

16 NEW SECTION. **Sec. 466.** SMALL FIRM FINANCIAL ASSISTANCE. (1)
17 Beginning July 1, 1997, firms with fewer than twenty-five workers that
18 face barriers to providing health insurance for their employees may,
19 upon application, be eligible to receive financial assistance with
20 funds set aside from the health services account. Firms with the
21 following characteristics shall be given preference in the distribution
22 of funds: (a) New firms, (b) employers with low average wages, (c)
23 employers with low profits, and (d) firms in economically distressed
24 areas.

25 (2) All employers in existence on or before July 1, 1997, who meet
26 the criteria set forth in this section, and rules adopted under this
27 section, may apply to the health services commission for assistance.
28 Such employers may not receive premium assistance beyond July 1, 2001.
29 New employers, who come into existence after July 1, 1997, may apply
30 for and receive premium assistance for a limited period of time, as
31 determined by the commission.

32 (3) The total funds available for small business assistance shall
33 not exceed one hundred fifty million dollars for the biennium beginning
34 July 1, 1997. Thereafter, the amount of total funds available for
35 premium assistance shall be determined by the office of financial
36 management, based on a forecast of inflation, employment, and the
37 number of eligible firms.

1 (4) By July 1, 1997, the health services commission, with
2 assistance from the small business advisory committee established in
3 section 404 of this act, shall develop specific definitions, rules, and
4 procedures governing all aspects of the small business assistance
5 program, including application procedures, thresholds regarding firm
6 size, wages, profits, and age of firm, and rules governing duration of
7 assistance.

8 (5) Final determination of the amount of the premium assistance to
9 be dispensed to an employer shall be made by the commission based on
10 rules, definitions, and procedures developed under this section. If
11 total claims for assistance are above the amount of total funds
12 available for such purposes, the commission shall have the authority to
13 prorate employer claims so that the amount of available funds is not
14 exceeded.

15 (6) The office of financial management, in consultation with the
16 commission, shall establish appropriate criteria for monitoring and
17 evaluating the economic and labor market impacts of the premium
18 assistance program and report its findings to the commission annually
19 through July 1, 2001.

20 **I. PUBLIC HEALTH SERVICES IMPROVEMENT PLAN**

21 NEW SECTION. **Sec. 467.** A new section is added to chapter 43.70
22 RCW to read as follows:

23 PUBLIC HEALTH SERVICES IMPROVEMENT PLAN. (1) The legislature finds
24 that the public health functions of community assessment, policy
25 development, and assurance of service delivery are essential elements
26 in achieving the objectives of health reform in Washington state. The
27 legislature further finds that the population-based services provided
28 by state and local health departments are cost-effective and are a
29 critical strategy for the long-term containment of health care costs.
30 The legislature further finds that the public health system in the
31 state lacks the capacity to fulfill these functions consistent with the
32 needs of a reformed health care system.

33 (2) The department of health shall develop, in consultation with
34 local health departments and districts, the state board of health, the
35 health services commission, area Indian health service, and other state
36 agencies, health services providers, and citizens concerned about
37 public health, a public health services improvement plan. The plan

1 shall provide a detailed accounting of deficits in the core functions
2 of assessment, policy development, assurance of the current public
3 health system, how additional public health funding would be used, and
4 describe the benefits expected from expanded expenditures.

5 (3) The plan shall include:

6 (a) Definition of minimum standards for public health protection
7 through assessment, policy development, and assurances;

8 (i) Enumeration of communities not meeting those standards;

9 (ii) A budget and staffing plan for bringing all communities up to
10 minimum standards;

11 (iii) An analysis of the costs and benefits expected from adopting
12 minimum public health standards for assessment, policy development, and
13 assurances;

14 (b) Recommended strategies and a schedule for improving public
15 health programs throughout the state, including:

16 (i) Strategies for transferring personal health care services from
17 the public health system, into the uniform benefits package where
18 feasible; and

19 (ii) Timing of increased funding for public health services linked
20 to specific objectives for improving public health; and

21 (c) A recommended level of dedicated funding for public health
22 services to be expressed in terms of a percentage of total health
23 service expenditures in the state or a set per person amount; such
24 recommendation shall also include methods to ensure that such funding
25 does not supplant existing federal, state, and local funds received by
26 local health departments, and methods of distributing funds among local
27 health departments.

28 (4) The department shall coordinate this planning process with the
29 study activities required in section 258 of this act.

30 (5) By March 1, 1994, the department shall provide initial
31 recommendations of the public health services improvement plan to the
32 legislature regarding minimum public health standards, and public
33 health programs needed to address urgent needs, such as those cited in
34 subsection (7) of this section.

35 (6) By December 1, 1994, the department shall present the public
36 health services improvement plan to the legislature, with specific
37 recommendations for each element of the plan to be implemented over the
38 period from 1995 through 1997.

1 (7) Thereafter, the department shall update the public health
2 services improvement plan for presentation to the legislature prior to
3 the beginning of a new biennium.

4 (8) Among the specific population-based public health activities to
5 be considered in the public health services improvement plan are:
6 Health data assessment and chronic and infectious disease surveillance;
7 rapid response to outbreaks of communicable disease; efforts to prevent
8 and control specific communicable diseases, such as tuberculosis and
9 acquired immune deficiency syndrome; health education to promote
10 healthy behaviors and to reduce the prevalence of chronic disease, such
11 as those linked to the use of tobacco; access to primary care in
12 coordination with existing community and migrant health clinics and
13 other not for profit health care organizations; programs to ensure
14 children are born as healthy as possible and they receive immunizations
15 and adequate nutrition; efforts to prevent intentional and
16 unintentional injury; programs to ensure the safety of drinking water
17 and food supplies; poison control; trauma services; and other
18 activities that have the potential to improve the health of the
19 population or special populations and reduce the need for or cost of
20 health services.

21 NEW SECTION. **Sec. 468.** A new section is added to chapter 41.05
22 RCW to read as follows:

23 AMERICAN INDIAN HEALTH CARE DELIVERY PLAN. Consistent with funds
24 appropriated specifically for this purpose, the authority shall
25 establish in conjunction with the area Indian health services system
26 and providers an advisory group comprised of Indian and non-Indian
27 health care facilities and providers to formulate an American Indian
28 health care delivery plan. The plan shall include:

29 (1) Recommendations to providers and facilities methods for
30 coordinating and joint venturing with the Indian health services for
31 service delivery;

32 (2) Methods to improve American Indian-specific health programming;
33 and

34 (3) Creation of co-funding recommendations and opportunities for
35 the unmet health services programming needs of American Indians.

36 **J. HEALTH ACCOUNTS**

1 NEW SECTION. **Sec. 469.** HEALTH SERVICES ACCOUNT. The health
2 services account is created in the state treasury. Moneys in the
3 account may be spent only after appropriation. Moneys in the account
4 may be expended only for maintaining and expanding health services
5 access for low-income residents, maintaining and expanding the public
6 health system, maintaining and improving the capacity of the health
7 care system, containing health care costs, and the regulation,
8 planning, and administering of the health care system.

9 NEW SECTION. **Sec. 470.** PUBLIC HEALTH SERVICES ACCOUNT. The
10 public health services account is created in the state treasury.
11 Moneys in the account may be spent only after appropriation. Moneys in
12 the account may be expended only for maintaining and improving the
13 health of Washington residents through the public health system. For
14 purposes of this section, the public health system shall consist of the
15 state board of health, the state department of health, and local health
16 departments and districts. Funds appropriated from this account to
17 local health departments and districts shall be distributed ratably
18 based on county population as last determined by the office of
19 financial management.

20 NEW SECTION. **Sec. 471.** HEALTH SYSTEM CAPACITY ACCOUNT. The
21 health system capacity account is created in the state treasury.
22 Moneys in the account may be spent only after appropriation. Moneys in
23 the account may be expended for the following purposes: Health data
24 systems; health systems and public health research; health system
25 regulation; health system planning, development, and administration;
26 and improving the supply and geographic distribution of primary health
27 service providers.

28 NEW SECTION. **Sec. 472.** PERSONAL HEALTH SERVICES ACCOUNT. The
29 personal health services account is created in the treasury. Moneys in
30 the account may be spent only after appropriation. Moneys in the
31 account may be expended for the support of subsidized personal health
32 services for low-income Washington residents.

33 **Sec. 473.** RCW 43.84.092 and 1993 c 4 s 9 are each amended to read
34 as follows:

1 EARNINGS OF INVESTMENTS. (1) All earnings of investments of
2 surplus balances in the state treasury shall be deposited to the
3 treasury income account, which account is hereby established in the
4 state treasury.

5 (2) Monthly, the state treasurer shall distribute the earnings
6 credited to the treasury income account. The state treasurer shall
7 credit the general fund with all the earnings credited to the treasury
8 income account except:

9 (a) The following accounts and funds shall receive their
10 proportionate share of earnings based upon each account's and fund's
11 average daily balance for the period: The capitol building
12 construction account, the Cedar River channel construction and
13 operation account, the Central Washington University capital projects
14 account, the charitable, educational, penal and reformatory
15 institutions account, the common school construction fund, the county
16 criminal justice assistance account, the county sales and use tax
17 equalization account, the data processing building construction
18 account, the deferred compensation administrative account, the deferred
19 compensation principal account, the department of retirement systems
20 expense account, the Eastern Washington University capital projects
21 account, the federal forest revolving account, the health services
22 account, the public health services account, the health system capacity
23 account, the personal health services account, the industrial insurance
24 premium refund account, the judges' retirement account, the judicial
25 retirement administrative account, the judicial retirement principal
26 account, the local leasehold excise tax account, the local sales and
27 use tax account, the medical aid account, the municipal criminal
28 justice assistance account, the municipal sales and use tax
29 equalization account, the natural resources deposit account, the
30 perpetual surveillance and maintenance account, the public employees'
31 retirement system plan I account, the public employees' retirement
32 system plan II account, the Puyallup tribal settlement account, the
33 resource management cost account, the site closure account, the special
34 wildlife account, the state employees' insurance account, the state
35 employees' insurance reserve account, the state investment board
36 expense account, the state investment board commingled trust fund
37 accounts, the supplemental pension account, the teachers' retirement
38 system plan I account, the teachers' retirement system plan II account,
39 the University of Washington bond retirement fund, the University of

1 Washington building account, the volunteer fire fighters' relief and
2 pension principal account, the volunteer fire fighters' relief and
3 pension administrative account, the Washington judicial retirement
4 system account, the Washington law enforcement officers' and fire
5 fighters' system plan I retirement account, the Washington law
6 enforcement officers' and fire fighters' system plan II retirement
7 account, the Washington state patrol retirement account, the Washington
8 State University building account, the Washington State University bond
9 retirement fund, and the Western Washington University capital projects
10 account. Earnings derived from investing balances of the agricultural
11 permanent fund, the normal school permanent fund, the permanent common
12 school fund, the scientific permanent fund, and the state university
13 permanent fund shall be allocated to their respective beneficiary
14 accounts. All earnings to be distributed under this subsection (2)(a)
15 shall first be reduced by the allocation to the state treasurer's
16 service fund pursuant to RCW 43.08.190.

17 (b) The following accounts and funds shall receive eighty percent
18 of their proportionate share of earnings based upon each account's or
19 fund's average daily balance for the period: The central Puget Sound
20 public transportation account, the city hardship assistance account,
21 the county arterial preservation account, the economic development
22 account, the essential rail assistance account, the essential rail
23 banking account, the ferry bond retirement fund, the grade crossing
24 protective fund, the high capacity transportation account, the highway
25 bond retirement fund, the highway construction stabilization account,
26 the highway safety account, the marine operating fund, the motor
27 vehicle fund, the motorcycle safety education account, the pilotage
28 account, the public transportation systems account, the Puget Sound
29 capital construction account, the Puget Sound ferry operations account,
30 the recreational vehicle account, the rural arterial trust account, the
31 special category C account, the state patrol highway account, the
32 transfer relief account, the transportation capital facilities account,
33 the transportation equipment fund, the transportation fund, the
34 transportation improvement account, and the urban arterial trust
35 account.

36 (3) In conformance with Article II, section 37 of the state
37 Constitution, no treasury accounts or funds shall be allocated earnings
38 without the specific affirmative directive of this section.

1 **K. EXCLUSIONS AND STUDIES**

2 NEW SECTION. **Sec. 474.** CODE REVISIONS AND WAIVERS. (1) The
3 commission shall determine the state and federal laws that would need
4 to be repealed, amended, or waived to implement chapter . . . , Laws of
5 1993 (this act), and report its recommendations, with proposed
6 revisions to the Revised Code of Washington, to the governor, and
7 appropriate committees of the legislature by July 1, 1994.

8 (2) The governor, in consultation with the commission, shall take
9 the following steps in an effort to receive waivers or exemptions from
10 federal statutes necessary to fully implement chapter . . . , Laws of
11 1993 (this act) to include, but not be limited to:

12 (a) Negotiate with the United States congress and the federal
13 department of health and human services, health care financing
14 administration to obtain a statutory or regulatory waiver of provisions
15 of the medical assistance statute, Title XIX of the federal social
16 security act that currently constitute barriers to full implementation
17 of provisions of chapter . . . , Laws of 1993 (this act) related to
18 access to health services for low-income residents of Washington state.
19 Such waivers shall include any waiver needed to require that: (i)
20 Medical assistance recipients enroll in managed care systems, as
21 defined in chapter . . . , Laws of 1993 (this act); and (ii) enrollee
22 point of service, cost-sharing levels adopted pursuant to section 449
23 of this act be applied to medical assistance recipients. In
24 negotiating the waiver, consideration shall be given to the degree to
25 which supplemental benefits should be offered to medicaid recipients,
26 if at all. Waived provisions may include and are not limited to:
27 Categorical eligibility restrictions related to age, disability,
28 blindness, or family structure; income and resource limitations tied to
29 financial eligibility requirements of the federal aid to families with
30 dependent children and supplemental security income programs;
31 administrative requirements regarding single state agencies, choice of
32 providers, and fee for service reimbursement; and other limitations on
33 health services provider payment methods.

34 (b) Negotiate with the United States congress and the federal
35 department of health and human services, health care financing
36 administration to obtain a statutory or regulatory waiver of provisions
37 of the medicare statute, Title XVIII of the federal social security act
38 that currently constitute barriers to full implementation of provisions

1 of chapter . . . , Laws of 1993 (this act) related to access to health
2 services for elderly and disabled residents of Washington state. Such
3 waivers shall include any waivers needed to implement managed care
4 programs. Waived provisions include and are not limited to:
5 Beneficiary cost-sharing requirements; restrictions on scope of
6 services; and limitations on health services provider payment methods.

7 (c) Negotiate with the United States congress and the federal
8 department of health and human services to obtain any statutory or
9 regulatory waivers of provisions of the United States public health
10 services act necessary to ensure integration of federally funded
11 community and migrant health clinics and other health services funded
12 through the public health services act into the health services system
13 established pursuant to chapter . . . , Laws of 1993 (this act). The
14 commission shall request in the waiver that funds from these sources
15 continue to be allocated to federally funded community and migrant
16 health clinics to the extent that such clinics' patients are not yet
17 enrolled in certified health plans.

18 (d) Negotiate with the United States congress to obtain a statutory
19 exemption from provisions of the Employee Retirement Income Security
20 Act that limit the state's ability to ensure that all employees and
21 their dependents in the state comply with the requirement to enroll in
22 certified health plans, and have their employers participate in
23 financing their enrollment in such plans.

24 (e) Request that the United States congress amend the Internal
25 Revenue Code to treat employee premium contributions to plans, such as
26 the basic health plan or the uniform benefits package offered through
27 a certified health plan, as fully deductible from adjusted gross
28 income.

29 (3) On or before December 1, 1995, the commission shall report the
30 following to the appropriate committees of the legislature:

31 (a) The status of its efforts to obtain the waivers provided in
32 subsection (2) of this section;

33 (b) If all federal statutory or regulatory waivers necessary to
34 fully implement chapter . . . , Laws of 1993 (this act) have not been
35 obtained:

36 (i) The extent to which chapter . . . , Laws of 1993 (this act) can be
37 implemented without receipt of all of such waivers; and

38 (ii) Changes in chapter . . . , Laws of 1993 (this act) necessary to
39 implement a residency-based health services system using one or a

1 limited number of sponsors, or an alternative system that will ensure
2 access to care and control health services costs.

3 NEW SECTION. **Sec. 475.** REPORTS OF HEALTH CARE COST CONTROL AND
4 ACCESS COMMISSION. In carrying out its powers and duties under chapter
5 . . . , Laws of 1993 (this act), the design of the uniform benefits
6 package, and the development of guidelines and standards, the
7 commission shall consider the reports of the health care cost control
8 and access commission established under House Concurrent Resolution No.
9 4443 adopted by the legislature in 1990. Nothing in chapter . . . ,
10 Laws of 1993 (this act) requires the commission to follow any specific
11 recommendation contained in those reports except as it may also be
12 included in chapter . . . , Laws of 1993 (this act) or other law.

13 NEW SECTION. **Sec. 476.** EVALUATIONS, PLANS, AND STUDIES. (1) By
14 July 1, 1997, the legislative budget committee either directly or by
15 contract shall conduct the following study:

16 A study to determine the desirability and feasibility of
17 consolidating the following programs, services, and funding sources
18 into the delivery and financing of uniform benefits package services
19 through certified health plans:

20 (a) State and federal veterans' health services;

21 (b) Civilian health and medical program of the uniformed services
22 (CHAMPUS) of the federal department of defense and other federal
23 agencies; and

24 (c) Federal employee health benefits.

25 (2) The legislative budget committee shall evaluate the
26 implementation of the provisions of chapter . . . , Laws of 1993 (this
27 act). The study shall determine to what extent chapter . . . , Laws of
28 1993 (this act) has been implemented consistent with the principles and
29 elements set forth in chapter . . . , Laws of 1993 (this act) and shall
30 report its findings to the governor and appropriate committees of the
31 legislature by July 1, 2003.

32 NEW SECTION. **Sec. 477.** FINANCIAL AND ACCOUNTING STRUCTURE OF
33 STATE PURCHASED HEALTH CARE. The commission, the office of financial
34 management, and the legislative evaluation and accountability program
35 committee shall jointly review the financial and accounting structure
36 of all current state-purchased health care programs and any new

1 programs established in chapter . . . , Laws of 1993 (this act). They
2 shall report to the legislature on or before December 1, 1994, with
3 recommendations on how to structure a state-purchased health services
4 budget that: (1) Meets federal and state audit requirements; (2)
5 exercises adequate fiscal and programmatic control; (3) provides
6 management and organizational accountability and control; and (4)
7 provides continuity with historical health services expenditure data.

8 NEW SECTION. **Sec. 478.** EVALUATION OF REFORM EFFORT. The office
9 of financial management may undertake or facilitate evaluations of
10 health care reform, including analysis of fiscal and economic impacts,
11 the effectiveness of managed care and managed competition, and effects
12 of reform on access and quality of service.

13 NEW SECTION. **Sec. 479.** COORDINATION OF CERTIFIED HEALTH PLANS AND
14 OTHER INSURANCE. (1) On or before December 1, 1994, the legislative
15 budget committee, whether directly or by contract, shall conduct a
16 study related to coordination of certified health plans and other
17 property and casualty insurance products. The goal of the study shall
18 be to determine methods for containing costs of health services paid
19 for through coverage underwritten by property and casualty insurers.

20 (2) The study shall address methods to integrate coverage sold by
21 property and casualty insurance companies that covers medical and
22 hospital expenses with coverage provided through certified health
23 plans.

24 NEW SECTION. **Sec. 480.** HOSPITAL REGULATION STUDY. The
25 legislative budget committee, through a competitive bidding process
26 restricted to those with suitable expertise to conduct such a study,
27 shall contract for an examination of local, state, and federal
28 regulations that apply to hospitals and shall report to the health care
29 policy committees of the legislature by July 1, 1994, on the following:

30 (1) An inventory of health and safety regulations that apply to
31 hospitals;

32 (2) A description of the costs to local, state, and federal
33 agencies for operating the regulatory programs;

34 (3) An estimate of the costs to hospitals to comply with the
35 regulations;

1 (4) A description of whether regulatory functions are duplicated
2 among different regulatory programs;

3 (5) An analysis of the effectiveness of regulatory programs in
4 meeting their safety and health objectives;

5 (6) An analysis of hospital charity care requirements under RCW
6 70.170.060 and their relevance under the health care reforms created
7 under chapter . . . , Laws of 1993 (this act);

8 (7) Recommendations on elimination or consolidation of unnecessary
9 or duplicative regulatory activities that would not result in a
10 reduction in the health and safety objectives.

11 NEW SECTION. **Sec. 481.** NURSING HOME STUDY. The legislative
12 budget committee, through a competitive bidding process restricted to
13 those with suitable expertise to conduct such a study, shall contract
14 for an examination of local, state, and federal regulations that apply
15 to nursing homes and shall report to the health care policy committees
16 of the legislature by July 1, 1994, on the following:

17 (1) An inventory of health and safety regulations that apply to
18 nursing homes;

19 (2) A description of the costs to local, state, and federal
20 agencies for operating the regulatory programs;

21 (3) An estimate of the costs to nursing homes to comply with the
22 regulations;

23 (4) A description of whether regulatory functions are duplicated
24 among different regulatory programs;

25 (5) An analysis of the effectiveness of regulatory programs in
26 meeting their safety and health objectives;

27 (6) Recommendations on elimination or consolidation of unnecessary
28 or duplicative regulatory activities that would not result in a
29 reduction in the health and safety objectives. The review shall
30 specifically address documentation or protocols that are redundant and
31 efficiencies that could be realized through the development of
32 standardized physicians' protocols for repetitive but nonlife-
33 threatening conditions.

34 NEW SECTION. **Sec. 482.** CERTIFIED HEALTH PLAN LICENSING STUDY.
35 The insurance commissioner shall undertake a study of the feasibility
36 and benefits of developing a single licensing category for certified
37 health plans that would replace current statues licensing disability

1 insurers, health care service contractors, and health maintenance
2 organizations. The commissioner shall report his or her findings and
3 recommendations to the legislature by January 1, 1994, and final
4 findings and recommendations to the legislature by October 1, 1994. In
5 conducting such study, the commissioner shall:

6 (1) Consider standards for the regulation and inclusion of
7 preferred provider organizations, independent practice associations,
8 and independent physician organizations under such new certified health
9 plan statute;

10 (2) Review existing capital and reserve statutes governing
11 insurers, contractors, and health maintenance organizations to
12 determine the appropriate level of capital and reserve for licensing of
13 certified health plans to protect consumers while encouraging
14 competition in the certified health plan market from new entrants into
15 the market;

16 (3) Review existing rate regulation of disability insurance
17 policies, health care service contracts, and health maintenance
18 agreements and propose a uniform approach for regulation of rates that
19 balances the need of certified health plans to freely compete and the
20 need to protect consumers from inadequate, excessive, or unfairly
21 discriminatory rates;

22 (4) Consider regulatory methods to ensure the adequate provision of
23 and contracting with health care facilities and providers by certified
24 health plans to meet the health care needs of enrollees of certified
25 health plans;

26 (5) Consider the need to modify existing insurance statutes and
27 regulations to govern the integration, development, and marketing of
28 health care coverage that would supplement the uniform benefits
29 package; and

30 (6) Consult with health care service contractors, health
31 maintenance organizations, disability insurance companies, and other
32 health care providers and facilities who would be affected by such
33 changes.

34 NEW SECTION. **Sec. 483.** CRIME VICTIMS' COMPENSATION MEDICAL
35 BENEFITS. (1) On or before January 1, 1995, the department of labor
36 and industries in coordination with the commission, shall complete a
37 study related to the medical services component of the crime victims'
38 compensation program of the department of labor and industries. The

1 goal of the study shall be to determine whether and how the medical
2 services component of the crime victims' compensation program can be
3 modified to provide appropriate medical services to crime victims in a
4 more cost-effective manner. In conducting the study, consideration
5 shall be given to at least the following factors: Required benefit
6 design, necessary statutory changes, and the use of managed care to
7 provide services to crime victims. The study shall evaluate at least
8 the following options:

9 (a) Whether the medical services component of the crime victims'
10 compensation program should be maintained within the department of
11 labor and industries, and its purchasing and other practices modified
12 to control costs and increase efficacy of health services provided to
13 crime victims;

14 (b) Whether the medical services component of the crime victims'
15 compensation program should be administered by the health care
16 authority as the state health care purchasing agent;

17 (c) Whether the medical services component of the crime victims'
18 compensation program should be included in the services offered by
19 certified health plans.

20 (2) The department of labor and industries shall present the
21 recommendations to the governor and the appropriate committees of the
22 legislature by January 1, 1995.

23 NEW SECTION. **Sec. 484.** MEDICAL CARE SAVINGS ACCOUNTS. The
24 Washington health services commission shall study and report to the
25 legislature on the feasibility of offering employer-funded medical care
26 savings account arrangements and reduced cost qualified higher
27 deductible insurance policies as a choice to K-12 system, state, and
28 local government employees in meeting their health care obligations.

29 **L. WORKERS' COMPENSATION**

30 NEW SECTION. **Sec. 485.** WORKERS' COMPENSATION MEDICAL BENEFITS.
31 On or before January 1, 1995, the health services commission, in
32 coordination with the department of labor and industries and the
33 workers' compensation advisory committee, shall study and make an
34 interim report, and on or before January 1, 1996, a final report, to
35 the governor and appropriate committees of the legislature on the
36 provision of medical benefits for injured workers under a consolidated

1 health care system. The study shall include a review of options and
2 recommendations for modifying the industrial insurance system to
3 provide medical services for injured workers in a more cost-effective
4 manner under a consolidated system, and may include consideration of
5 the purchase of industrial insurance medical benefits through the
6 health care authority or the inclusion of industrial insurance medical
7 benefits in the services offered by certified health plans or other
8 appropriate options. The commission should also give consideration to
9 at least the following issues: The use of managed care and the effect
10 of managed care options on the injured workers' choice of health
11 services provider; the potential cost savings or other impacts of
12 various consolidation options; the benefit structure required under
13 industrial insurance; the potential for consolidation to meet or exceed
14 existing medical cost management of the medical aid fund; the impact of
15 separating the medical management of claims from the disability
16 management of claims; the relationship between return-to-work efforts,
17 medical services, and disability prevention; the relationship between
18 medical services and rehabilitation services; and the effects of the
19 quasi-judicial system that determines industrial insurance rights and
20 obligations. In addition, the final report shall include a proposed
21 plan and timeline for including the medical benefits of the industrial
22 insurance system in the services offered by certified health plans.
23 The proposed plan shall assure that:

24 (1) The plan shall not take effect until at least ninety-seven
25 percent of state residents have access to the uniform benefits package
26 as required in chapter ..., Laws of 1993 (this act);

27 (2) The uniform benefits package of the certified health plan will
28 provide benefits for injured workers that are at least equivalent to
29 the medical benefits provided to injured workers under Title 51 RCW as
30 determined by the department of labor and industries as of the
31 effective date of the plan, including payments for services that are
32 ancillary to industrial insurance medical benefits, such as but not
33 limited to medical examinations for permanent disabilities;

34 (3) Other nonmedical benefits required to be provided under Title
35 51 RCW, such as but not limited to total or partial disability benefits
36 or vocational rehabilitation benefits, are not affected;

37 (4) Employers who do not choose to become certified health plans
38 under chapter..., Laws of 1993 (this act), will continue to be required
39 to provide industrial insurance medical benefits under Title 51 RCW;

1 (5) Employees participating in the plan shall not be required to
2 pay deductibles, copayments, or other point of service charges for
3 services related to industrial insurance injuries or diseases, such
4 costs to be paid by the department of labor and industries or self-
5 insured employer, as applicable;

6 (6) The plan includes a mechanism to return to workers and
7 employers, in equal shares, any savings that are realized in the costs
8 of medical services for injured workers, as identified by the
9 department of labor and industries;

10 (7) The majority of the employer's employees or, if the employees
11 are represented for collective bargaining purposes, the exclusive
12 bargaining representative voluntarily agree to the employer's
13 participation in the plan.

14 NEW SECTION. **Sec. 486.** MANAGED CARE PILOT PROJECTS. (1) The
15 department of labor and industries, in consultation with the workers'
16 compensation advisory committee, may conduct pilot projects to purchase
17 medical services for injured workers through managed care arrangements.
18 The projects shall assess the effects of managed care on the cost and
19 quality of, and employer and employee satisfaction with, medical
20 services provided to injured workers.

21 (2) The pilot projects may be limited to specific employers. The
22 implementation of a pilot project shall be conditioned upon a
23 participating employer and a majority of its employees, or, if the
24 employees are represented for collective bargaining purposes, the
25 exclusive bargaining representative, voluntarily agreeing to the terms
26 of the pilot. Unless the project is terminated by the department, both
27 the employer and employees are bound by the project agreements for the
28 duration of the project.

29 (3) Solely for the purpose and duration of a pilot project, the
30 specific requirements of Title 51 RCW that are identified by the
31 department as otherwise prohibiting implementation of the pilot project
32 shall not apply to the participating employers and employees to the
33 extent necessary for conducting the project. Managed care arrangements
34 for the pilot projects may include the designation of doctors
35 responsible for the care delivered to injured workers participating in
36 the projects.

37 (4) The projects shall conclude no later than January 1, 1996. The
38 department shall present the results of the pilot projects and any

1 recommendations related to the projects to the governor and appropriate
2 committees of the legislature on or before October 1, 1996.

3 **M. MISCELLANEOUS**

4 NEW SECTION. **Sec. 487.** SHORT TITLE. This act may be known and
5 cited as the Washington health services act of 1993.

6 **Sec. 488.** RCW 42.17.2401 and 1991 c 200 s 404 are each amended to
7 read as follows:

8 EXECUTIVE STATE OFFICERS. For the purposes of RCW 42.17.240, the
9 term "executive state officer" includes:

10 (1) The chief administrative law judge, the director of
11 agriculture, the administrator of the office of marine safety, the
12 administrator of the Washington basic health plan, the director of the
13 department of services for the blind, the director of the state system
14 of community and technical colleges, the director of community
15 development, the secretary of corrections, the director of ecology, the
16 commissioner of employment security, the chairman of the energy
17 facility site evaluation council, the director of the energy office,
18 the secretary of the state finance committee, the director of financial
19 management, the director of fisheries, the executive secretary of the
20 forest practices appeals board, the director of the gambling
21 commission, the director of general administration, the secretary of
22 health, the administrator of the Washington state health care
23 authority, the executive secretary of the health care facilities
24 authority, the executive secretary of the higher education facilities
25 authority, the director of the higher education personnel board, the
26 executive secretary of the horse racing commission, the executive
27 secretary of the human rights commission, the executive secretary of
28 the indeterminate sentence review board, the director of the department
29 of information services, the director of the interagency committee for
30 outdoor recreation, the executive director of the state investment
31 board, the director of labor and industries, the director of licensing,
32 the director of the lottery commission, the director of the office of
33 minority and women's business enterprises, the director of parks and
34 recreation, the director of personnel, the executive director of the
35 public disclosure commission, the director of retirement systems, the
36 director of revenue, the secretary of social and health services, the

1 chief of the Washington state patrol, the executive secretary of the
2 board of tax appeals, the director of trade and economic development,
3 the secretary of transportation, the secretary of the utilities and
4 transportation commission, the director of veterans affairs, the
5 director of wildlife, the president of each of the regional and state
6 universities and the president of The Evergreen State College, each
7 district and each campus president of each state community college;

8 (2) Each professional staff member of the office of the governor;

9 (3) Each professional staff member of the legislature; and

10 (4) Central Washington University board of trustees, board of
11 trustees of each community college, each member of the state board for
12 community and technical colleges (~~(education)~~), state convention and
13 trade center board of directors, committee for deferred compensation,
14 Eastern Washington University board of trustees, Washington economic
15 development finance authority, The Evergreen State College board of
16 trustees, forest practices appeals board, forest practices board,
17 gambling commission, Washington health care facilities authority, each
18 member of the Washington health services commission, higher education
19 coordinating board, higher education facilities authority, higher
20 education personnel board, horse racing commission, state housing
21 finance commission, human rights commission, indeterminate sentence
22 review board, board of industrial insurance appeals, information
23 services board, interagency committee for outdoor recreation, state
24 investment board, liquor control board, lottery commission, marine
25 oversight board, oil and gas conservation committee, Pacific Northwest
26 electric power and conservation planning council, parks and recreation
27 commission, personnel appeals board, personnel board, board of pilotage
28 (~~(commissioners)~~) commissioners, pollution control hearings board,
29 public disclosure commission, public pension commission, shorelines
30 hearing board, (~~(state)~~) public employees' benefits board, board of tax
31 appeals, transportation commission, University of Washington board of
32 regents, utilities and transportation commission, Washington state
33 maritime commission, Washington public power supply system executive
34 board, Washington State University board of regents, Western Washington
35 University board of trustees, and wildlife commission.

36 **Sec. 489.** RCW 43.20.050 and 1992 c 34 s 4 are each amended to read
37 as follows:

1 STATE BOARD OF HEALTH--PUBLIC HEALTH POLICY. (1) The state board
2 of health shall provide a forum for the development of public health
3 policy in Washington state. It is authorized to recommend to the
4 secretary means for obtaining appropriate citizen and professional
5 involvement in all public health policy formulation and other matters
6 related to the powers and duties of the department. It is further
7 empowered to hold hearings and explore ways to improve the health
8 status of the citizenry.

9 (a) At least every five years, the state board shall convene
10 regional forums to gather citizen input on public health issues.

11 (b) Every two years, in coordination with the development of the
12 state biennial budget, the state board shall prepare the state public
13 health report that outlines the health priorities of the ensuing
14 biennium. The report shall:

15 (i) Consider the citizen input gathered at the ((health)) forums;

16 (ii) Be developed with the assistance of local health departments;

17 (iii) Be based on the best available information collected and
18 reviewed according to RCW 43.70.050 and recommendations from the
19 council;

20 (iv) Be developed with the input of state health care agencies. At
21 least the following directors of state agencies shall provide timely
22 recommendations to the state board on suggested health priorities for
23 the ensuing biennium: The secretary of social and health services, the
24 health care authority administrator, the insurance commissioner, the
25 superintendent of public instruction, the director of labor and
26 industries, the director of ecology, and the director of agriculture;

27 (v) Be used by state health care agency administrators in preparing
28 proposed agency budgets and executive request legislation;

29 (vi) Be submitted by the state board to the governor by ((June))
30 January 1 of each even-numbered year for adoption by the governor. The
31 governor, no later than ((September)) March 1 of that year, shall
32 approve, modify, or disapprove the state public health report.

33 (c) In fulfilling its responsibilities under this subsection, the
34 state board ((shall)) may create ad hoc committees or other such
35 committees of limited duration as necessary. ((Membership should
36 include legislators, providers, consumers, bioethicists, medical
37 economics experts, legal experts, purchasers, and insurers, as
38 necessary.))

1 (2) In order to protect public health, the state board of health
2 shall:

3 (a) Adopt rules necessary to assure safe and reliable public
4 drinking water and to protect the public health. Such rules shall
5 establish requirements regarding:

6 (i) The design and construction of public water system facilities,
7 including proper sizing of pipes and storage for the number and type of
8 customers;

9 (ii) Drinking water quality standards, monitoring requirements, and
10 laboratory certification requirements;

11 (iii) Public water system management and reporting requirements;

12 (iv) Public water system planning and emergency response
13 requirements;

14 (v) Public water system operation and maintenance requirements;

15 (vi) Water quality, reliability, and management of existing but
16 inadequate public water systems; and

17 (vii) Quality standards for the source or supply, or both source
18 and supply, of water for bottled water plants.

19 (b) Adopt rules and standards for prevention, control, and
20 abatement of health hazards and nuisances related to the disposal of
21 wastes, solid and liquid, including but not limited to sewage, garbage,
22 refuse, and other environmental contaminants; adopt standards and
23 procedures governing the design, construction, and operation of sewage,
24 garbage, refuse and other solid waste collection, treatment, and
25 disposal facilities;

26 (c) Adopt rules controlling public health related to environmental
27 conditions including but not limited to heating, lighting, ventilation,
28 sanitary facilities, cleanliness and space in all types of public
29 facilities including but not limited to food service establishments,
30 schools, institutions, recreational facilities and transient
31 accommodations and in places of work;

32 (d) Adopt rules for the imposition and use of isolation and
33 quarantine;

34 (e) Adopt rules for the prevention and control of infectious and
35 noninfectious diseases, including food and vector borne illness, and
36 rules governing the receipt and conveyance of remains of deceased
37 persons, and such other sanitary matters as admit of and may best be
38 controlled by universal rule; and

1 (f) Adopt rules for accessing existing data bases for the purposes
2 of performing health related research.

3 (3) The state board may delegate any of its rule-adopting authority
4 to the secretary and rescind such delegated authority.

5 (4) All local boards of health, health authorities and officials,
6 officers of state institutions, police officers, sheriffs, constables,
7 and all other officers and employees of the state, or any county, city,
8 or township thereof, shall enforce all rules adopted by the state board
9 of health. In the event of failure or refusal on the part of any
10 member of such boards or any other official or person mentioned in this
11 section to so act, he shall be subject to a fine of not less than fifty
12 dollars, upon first conviction, and not less than one hundred dollars
13 upon second conviction.

14 (5) The state board may advise the secretary on health policy
15 issues pertaining to the department of health and the state.

16 NEW SECTION. **Sec. 490.** SEVERABILITY. If any provision of this
17 act or its application to any person or circumstance is held invalid,
18 the remainder of the act or the application of the provision to other
19 persons or circumstances is not affected.

20 NEW SECTION. **Sec. 491.** SAVINGS CLAUSE. The enactment of this act
21 does not have the effect of terminating, or in any way modifying, any
22 obligation or any liability, civil or criminal, which was already in
23 existence on the effective date of this act.

24 NEW SECTION. **Sec. 492.** CAPTIONS. Captions used in this act do
25 not constitute any part of the law.

26 NEW SECTION. **Sec. 493.** CODIFICATION. (1) Sections 401 through
27 407, 409, 425, 427 through 430, and 447 through 466 of this act shall
28 constitute a new chapter in Title 43 RCW.

29 (2) Sections 426 and 431 through 446 of this act shall constitute
30 a new chapter in Title 48 RCW.

31 (3) Sections 458 through 462 of this act shall constitute a new
32 chapter in Title 48 RCW.

33 NEW SECTION. **Sec. 494.** RESERVATION OF LEGISLATIVE AUTHORITY. The
34 legislature reserves the right to amend or repeal all or any part of

1 this act at any time and there shall be no vested private right of any
2 kind against such amendment or repeal. All the rights, privileges, or
3 immunities conferred by this act or any acts done pursuant thereto
4 shall exist subject to the power of the legislature to amend or repeal
5 this act at any time.

6 NEW SECTION. **Sec. 495.** EFFECTIVE DATE CLAUSE. This act is
7 necessary for the immediate preservation of the public peace, health,
8 or safety, or support of the state government and its existing public
9 institutions, and shall take effect July 1, 1993, except for:

10 (1) Sections 234 through 257 of this act, which shall take effect
11 July 1, 1995; and

12 (2) Sections 301 through 303 of this act, which shall take effect
13 January 1, 1996.

14 NEW SECTION. **Sec. 496.** NULL AND VOID. If specific funding for
15 section 418 of this act, referencing section 418 of this act by bill
16 and section number, is not provided by June 30, 1993, in the omnibus
17 appropriations act, section 418 of this act shall be null and void.

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